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# BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

## V. HEAT PROCESSING THE SEALED CONTAINER

● Previously, we have described how raw food material is sealed in the tin container after proper preparatory treatment. After sealing, the next important step in commercial canning is the heat process, or "process" as it is called in the industry.

Essentially, the processing operation involves exposure of the sealed container to hot or boiling water, or to steam under pressure, for the correct period of time. The purpose of the process is to destroy pathogenic or spoilage organisms which may be present on raw food material; the seal on the can then prevents re-infection of the foods by such organisms. Thus, the sealing and processing operations combine to insure a sound, wholesome canned product.

It is not possible here to review all factors which must be considered in the establishment of an adequate heat process for any specific product. Such factors have been briefly discussed in recent publications (1, 2). It must suffice to state that, in general, commercial processing operations are divided into two general types, depending upon the acidity of the food being canned.

The "acid" foods—including the common fruits and certain vegetables or vegetable products whose pH values fall below 4.5—are quite easily heat processed. With such foods it is only necessary to heat the sealed container long enough to permit the attainment of a definite temperature

in the center of the can (usually 200°F. or slightly less). In fact, some acid products may be processed by filling sufficiently hot, sealing and inverting the cans, and cooling without further process.

The "non-acid" foods—such as meat, sea foods, milk and most of the common vegetables—require temperatures above that of boiling water for adequate heat processing. Such foods are processed under steam pressure in a closed "retort", usually at a temperature of 240°F. Years of research have made possible the issuance for the guidance of modern canners of a bulletin listing recommended process schedules for the non-acid products (3).

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(1) 1938 Food Research 3, 13.

(2) 1937. J. Amer. Med. Assn. 109, 1046.

(3) 1937. Natl. Canners Assn. Bull. 26L, 3rd ed.

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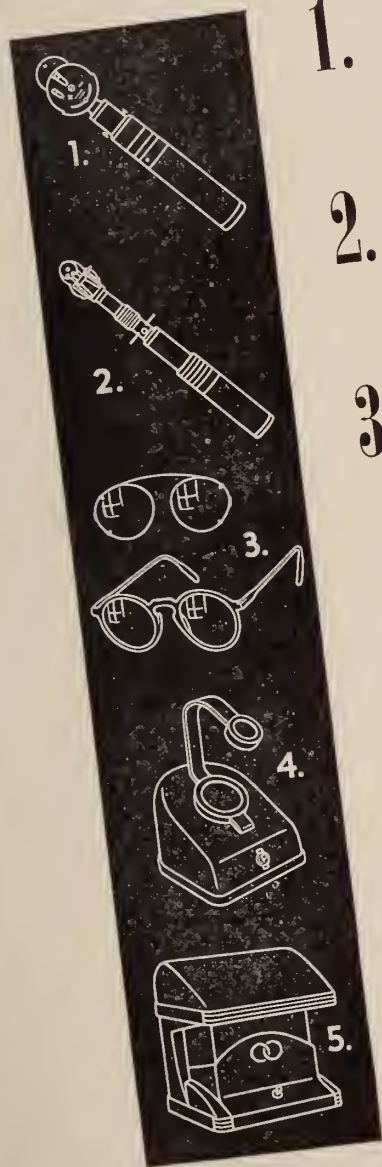


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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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Number 1

## THE ROLE OF THE IMPONDERABLES IN SURGERY\*

J. M. T. FINNEY, M.D.,  
Baltimore

Shakespeare, with his keen insight into human nature, and his wonderful faculty of expression, makes Hamlet say to Horatio,

"There are more things in Heaven and Earth,  
Horatio,  
Than are dreamt of in your philosophy."

In line with these pregnant words of Hamlet, the speaker, not without considerable hesitation, ventures to present for your consideration some thoughts based upon certain of his own observations and those of others of his surgical confreres, as related to him by them. He is well aware of the fact that what he has to offer constitutes a distinct departure from well trodden scientific paths into the realm of conjecture, more or less philosophical and speculative in character, where scientific proof of the soundness of one's conclusions, drawn from the phenomena observed, is not always forthcoming, and consequently their correctness may at times be fairly challenged. The comprehensiveness of the subject and the time limitations, are offered as an excuse for the rather sketchy form of its presentation.

At the outset, the speaker wishes to stress the fact, which is generally well recognized, that at times, in a given case, without a properly performed autopsy, the exact cause of death may well be subject to question. Caution should be exercised, therefore, in order to avoid drawing too hasty conclusions from insufficient evidence.

In the orthodox management of a case of illness, the physician or surgeon in attendance is largely concerned with three main factors—the diagnosis, the prognosis, and the treatment. However, in order to conserve the best interests of his patient, the careful, well-informed surgeon—and I am speaking now from

the point of view of the surgeon—will take cognizance of certain *special* factors, in addition to those common to all surgical operations with which everyone is more or less familiar, such as the administration of the anesthetic; infection, and the means used to prevent it; hemorrhage; postoperative complications, etc. The particular factors that I have in mind, and which I wish to bring to your attention, for want of a better term, I will call the Imponderables. They intimately concern the emotions, and have to do with the mental or spiritual, rather than the physical make-up of the patient. In other words, they constitute the human equation. The effect of these imponderable but very potent forces upon his welfare, may at times become very pronounced even to the extent of determining the ultimate result of the operation, whether success or failure, life or death. Hence, the necessity for a thorough understanding of them and their adequate control, where possible. These imponderable factors are many and varied, and may be divided into two main classes: first, favorable as regards their effect upon the morale of the prospective patient, such as courage, confidence, hope, faith, the *will* to live; religious faith cures, such for instance, as are reported from the grotto of Our Lady of Lourdes in France, or the Shrine of St. Anne de Beaupre in Canada, and so on; second, the unfavorable effects—the will to die, fear, anger, grief, despair, superstitions; presentiments, omens, dreams, anniversaries, witchcraft, and so on. I recognize full well that scientific proof as to the real effect upon the patient of the factors just enumerated is not by any means always forthcoming, but that in certain cases it is very potent, can no longer be denied. Autopsies in the fatal cases are usually not to be had, or may show little that is definite—hence, the true cause of death in individual cases may not be absolutely determined; nor, on the other hand, can the exact cause of the recovery when it takes place be definitely stated. I am not now attempting to explain the phenomena noted, which frankly, I confess my inability to do,

\*Delivered by invitation at the Sixty-fifth Annual Meeting of the Florida Medical Association, Miami, May 9, 10 and 11, 1938.

but rather am putting on record certain interesting facts that have been observed by myself and others, for explanation later, if and when our knowledge concerning their causes increases sufficiently to make it possible.

It will be generally admitted, I believe, that the state of mind in which the patient approaches a surgical operation, exerts a very real influence for good or evil, upon its outcome. A patient who is "scared to death," to use a common expression, or who is greatly worried by gloomy forebodings as to the result of the operation; or who has made up his mind that he is surely going to die, is in a much less favorable condition to undergo a serious surgical operation and make a satisfactory recovery therefrom, than one whose mind is at rest, and whose apprehensions and emotions are not all stirred up. As I acquire wider experience, I am more and more impressed with the advisability of paying greater attention, by the operating surgeon, to the mental state of the patient about to be operated upon. Of course, it takes time and trouble to do this, and the surgeon's time is limited and valuable as well. So much so, that he is unable or, more likely, unwilling to give up much of it to talk to, and to reassure nervous or apprehensive patients concerning the nature and probable outcome of the proposed operation. I am becoming all the time more and more convinced that it is not enough simply to inform a patient in a casual, matter of fact sort of way that upon a certain day at a certain hour, he will be operated upon, and let it go at that. The ideas current in the lay mind with regard to the discomforts, dangers, and possible unsatisfactory results inseparably connected with a surgical operation, are often so erroneous and so terrifying as to constitute a real menace to the success of the operation, to say nothing of the needless mental suffering that is thereby entailed. The careful, conscientious surgeon will, therefore, before undertaking any operative procedure, be sure to take the time to satisfy himself that his patient is properly informed as to just what it is proposed to do, and why, and so far as it is humanly possible to foretell, just what it is hoped to accomplish. In this way only can that degree of confidence and mutual cooperation, so necessary to the

fullest measure of success, be established between surgeon and patient. But some will say: "I haven't the time. I can't operate on but half the patients that I do now, if I spend so much time with each individual patient." The answer is simple and sure. No surgeon has the moral right to undertake to do more than he can properly accomplish.

Instances are not lacking to show that, under the stimulus of some strong emotion, such as love, hate, patriotism, religious zeal, devotion to an individual, to an ideal, to a cause, or what not, men and women may rise to heights of physical endurance and accomplishment quite beyond their normal capabilities. May this not also be correspondingly true of one's mental and spiritual faculties? It would appear that ample evidence is accumulating to support this contention.

It is my purpose in this paper to call attention to a class of cases that has interested me greatly. Perhaps I may have been unduly impressed by what would seem to be, if not a definite entity, at least a condition of mind in the patient, that is capable of affecting to a marked degree, either favorably or unfavorably, the result of a surgical operation, which is the question just now under consideration.

The salutary effect, to which reference has already been made, that entire confidence in one's doctor, be he medical or surgical, exerts upon a patient, is a matter of common knowledge and remark. Who has not met with instances where the whole aspect of a case has been quickly changed by the effect upon the morale of the patient that renewed confidence inspires? On the other hand, lack of confidence in one's physician or surgeon creates an atmosphere of suspicion and distrust, which is most unfavorable to a satisfactory outcome of any prescribed course of treatment, whether medical or surgical. As a result of these observations, the speaker has become impressed with the fact upon which he wishes to lay especial emphasis that in preparing for a surgical operation there is something more to be taken into account than merely the diagnosis, the aseptic technique, the administration of the anesthetic and the use of the knife, as vitally important as all these are, namely, the state of mind of the patient at the time of the operation.

Evidence is not wanting to show that in



some quarters at least, modern science is beginning to take cognizance of certain psychic phenomena, the existence and significance of which has hitherto been largely ignored.

It is a fact worthy of note that while casual interest in psychic research had existed in the scientific mind since a very early date, yet it was not until about fifty years ago that any organized effort was undertaken to make a serious study of the subject. However, in the last half century many prominent scientists and men of letters have given the matter careful consideration.

The American Society for Psychic Research was founded in 1925.

In this country intensive studies of various phases of the subject have recently been undertaken in certain universities,—Clark and Duke, for instance. Among the most recent converts to the study of psychical phenomena as representing a field which science can no longer ignore, are such outstanding scientists as Alexis Carrell, whose recent writings upon this subject have attracted much attention, and Compton of stratosphere fame. It will thus be seen that the observations here recorded, explain them as you may, are by no means isolated instances. It is well, however, in the present uncertainty, for scientific men to keep open minds in respect to psychical research, until sufficient knowledge upon which to base a more definite opinion, has been acquired.

The speaker wishes it clearly understood that he is neither a psychologist nor a psychiatrist, nor even a physiologist, nor yet a spiritualist. He is simply an observant surgeon with an open mind, greatly interested in the varied phenomena both physical and psychical, that from time to time have presented themselves in the course of his practice, and scientifically curious to know the reasons why, in order that such knowledge may enable him to take better care of his patients.

It is hoped that this discussion may direct the attention of that portion of the profession to whose notice it may come, to a phase of surgery which has hitherto received rather scant attention, namely, the human element. Every one will agree that the surgeon has no more right to inflict needless mental anguish than he has to cause unnecessary physical pain. Both tend to lower the resistance of

the patient and render him a less favorable surgical risk. Therefore, one of the first obligations of the surgeon when he assumes the responsibility of the care of a patient is to acquaint himself with, and to remove, so far as humanly possible, all obstacles, physical and mental, to a successful conduct of the case. In order to do this satisfactorily, it is essential that the surgeon should come to know as intimately as possible what the old family doctor used to call "the constitution" of his patient. Until quite recently it was customary in informed circles, to smile complacently when this expression was used. Now, however, its true significance is beginning to be more generally recognized.

Let us for a moment consider a few of the more important emotional elements that exert far-reaching effects upon the patient about to be operated upon. There is, first, the element of fear. That there is a wide-spread feeling in the public mind, that there is such a thing as a person's dying from sheer fright, is shown by the frequency with which one hears the expression "scared to death" used, and the number of cases that one finds in the public print, both lay and professional, where death has been ascribed to this cause. Physiologists have studied closely the effects produced in animals by fear, and rage, which are very similar. They tell us that any strong emotion brings the sympatho-adrenal mechanism into supreme action, and thus it is perfectly possible that death may be precipitated in an individual already the subject of certain nervous, vascular or other affections that make him more vulnerable to emotional storms,—such, for instance, as are inseparable from the contemplation of a surgical operation.

To quote again from Shakespeare: in Hamlet, Act V, Scene 1, is given a classical description of a victim of severe fright. Says the Ghost to Hamlet:

"I could a tale unfold whose lightest word  
Would harrow up thy soul, freeze thy  
young blood,

Make thy two eyes, like stars, start from  
their spheres,

Thy knotted and combined locks to part,  
And each particular hair to stand on end,  
Like quills upon the fretful porpentine!"

A study of this vivid picture of severe fright, a not uncommon condition in highly

nervous patients about to undergo a surgical operation, is all that is necessary to convince one that such a state of mind, with its accompanying functional disturbances, is surely not conducive to the success of a surgical operation. One of the best known of the traditions of surgery, handed down since the time of Hippocrates, is that in order to insure the best postoperative results, the physiological processes involved in wound healing should not be interfered with, but aided as much as possible. To this end, tranquility of mind, bodily rest, and freedom from pain are all factors of prime importance. In spite of the fact that everyone who knows anything about the healing of wounds is aware of the fundamental nature of the facts just stated, nevertheless, how much attention does the average surgeon, in his busy life, pay to them. To be sure, ordinary care is usually exercised to keep the patient quiet, and to relieve unnecessary pain, but that is all. Experience, however, will show that time taken to gain the patient's confidence, to remove doubts and fears from his mind, to explain just what it is proposed to do and why, what the chances of recovery of health and bodily functions are, is time well spent, and will yield rich returns in peace of mind, better wound healing, a more rapid and complete convalescence, and not infrequently, the making of a lasting friend out of one's patient. The "sine quae non" to the accomplishment of the best in surgery, is attention to detail, mental, physical and technical. It is nothing short of the best that the surgeon should strive after in his work, not simply that it should be just good enough. It is the hundredth case that the surgeon should be constantly striving for, and preparing himself to meet. This is the case, the successful management of which will tax the resources of the surgeon to the utmost. The ninety-nine will likely take care of themselves, either because of, or (horrible thought), perhaps even in spite of, whatever the surgeon may do.

In a recent paper, Guthrie has emphasized the necessity for, and the advantages to be gained by, the elimination of fear from the surgical patient's mind. His paper is timely and well worth reading by every surgeon. Cannon and Freeman have contributed very materially to our knowledge concerning the effect of the emotions, especially fear and

rage, upon the bodily functions. Cannon describes in detail the disturbed physiology in animals brought about by rage which is closely akin to that of fear. In addition to the external evidences so graphically described by Hamlet's Ghost, Cannon calls attention to certain deeper changes produced, such as "acceleration of the heart beat, rise of blood pressure, increase of blood sugar, redistribution of blood in the body, a greater output of adrenal secretions, and a digestive process that is markedly inhibited." He also shows "the way in which the emotional level, by affecting the sympathetic system may have a harmful influence on the organism as a whole." Those engaged in medical practice, whether physicians or surgeons, have many opportunities to observe instances in which strong emotions may in various ways greatly disturb the normal functioning of the human organism. This is especially true in resulting disturbances of digestion, of metabolism, and of heart action as described by Cannon. He further emphasizes the fact that in "the case of strong emotional excitement, the internal environment of the body may be so affected as to determine for weal or woe, the fate of the whole organism." It is thus seen that harmful emotions such as fear, grief, disappointment, despondency and the like, may lower a patient's resistance, upset the health balance of the body, retard convalescence, interrupt recovery and, when very intense, especially if associated with grave organic disease or severe pain, may actually cause death. "Therefore", asks Guthrie, "is not an earnest effort upon our part to eliminate harmful emotions from our patients' minds justifiable?" To which question a unanimous affirmative answer will be given. In order to accomplish this, team-work must be developed among all those who have to do with the patient—doctors, nurses, even orderlies, all hospital attaches alike. Every effort should be made to get and keep the patient in the best frame of mind possible while waiting in the hospital ward for the surgical operation. Irreparable harm may be done during this critical period by disturbing sights, sounds and tales told by others, when the patient about to be operated upon sorely needs the moral support of all those associated with him. He needs to be reassured and strengthened physically, mentally, and spirit-

ually, to undergo the severe strain of the proposed operation. A spirit of optimism should characterize the entire staff, and an atmosphere of hopefulness should pervade both hospital and ward—not silly Pollyanna-like stuff, but a firm belief, born of unshaken faith, in the will and ability of the surgeon to accomplish the desired result which will impart to the patient a like feeling of confidence.

Hope and confidence are two of the strongest bulwarks to sustain the courage of the patient to endure the trials, dangers and suffering, both physical and mental, that not infrequently attend surgical operations. Think for a moment, of what it would mean to each one of us personally to have to undergo an ordeal of this sort, with no confidence in the skill or ability of the operator, no assurance as to the outcome of the operation, only harassing doubts and fears. I recall vividly the case, many years ago, of a middle-aged Jewess with marked hyperthyroidism, associated with a moderate enlargement of the thyroid gland. It was proposed simply to ligate the vessels, the usual preliminary procedure in such cases in those days. The patient who was extremely nervous and apprehensive, had been placed, preparatory to the operation, upon the old Halstead type of operating table then in use. As some of you may remember, it was a relic of the old antiseptic, irrigation surgery days, made entirely of wood, with an elevated border about four inches high around the edges of the table, upon which was placed a narrow loose board, which served as the top. While preparing the patient for the ether, and before its administration had begun, the end of the board slipped off inside of the elevated rim of the table, and together with the patient, suddenly dropped the four inches. The patient uttered a startled cry, and was dead. Unfortunately, no autopsy could be had, so the actual cause of death was undetermined. But whatever the actual cause, there can be no doubt but that death was precipitated by the shock and fright due to the sudden, unexpected jolt.

On the other hand what shall we say with regard to the element of faith either in the personality of the surgeon, in the efficacy of the particular remedy used, or in the power of prayer to accomplish superhuman results?

There are comparatively few, I fancy, who do not share the prevailing belief that the days of miracles are over. But, however one may explain them, and there is no unanimity of opinion upon this point; and in spite of extravagant claims of its devotees, candor compels the unprejudiced observer to admit that many remarkable cases are on record where at least symptomatic cures have been brought about by faith in some supernatural agency, be it prayer to the Supreme Being, or belief in the power of faith to heal. To deny the reality of a phenomenon, simply because one cannot explain it, is the height of folly. Hamlet was right when he said, as quoted at the beginning of this paper, "There are more things in Heaven and Earth, Horatio, than are dreamt of in your philosophy." There are many things incomprehensible to the finite mind and beyond the ability of science at the present time, to explain, that nevertheless may at times appear very real. It is well, then, that the surgeon should continue to maintain an open mind in matters as yet not finally settled.

The will to live, a greatly to be desired frame of mind in the psychology of the patient about to be operated upon, flourishes best in an atmosphere pervaded with confidence both in the personality and ability of the surgeon, and in the outcome of the operation. Hence, we recognize at once, that this imponderable factor of confidence and trust on the part of the patient, is one of the best assets that the surgeon has in his work. If one tries to analyze the basis upon which it is founded, at once one meets with difficulties. That it is not always based solely upon merit is certain, because now and again one meets with instances where some ignorant or unscrupulous quack possesses to a remarkable degree the ability to inspire confidence in his patients and, strange to say, the latter are by no means all of the ignorant and uneducated classes. Some highly educated persons are most foolish in their choice of medical advisors. To be sure, both education and ability do count in the long run, but personality, that quality so difficult to describe and yet so well understood, along with a profound understanding of and respect for human nature and an evident interest in the patient himself, are the attributes that more than any others in-



spire confidence and trust in the average patient.

Who has not met with instances, a sick mother with an invalid child perhaps, where the life of the former has been despaired of, but where, in spite of this, her indomitable will to live for the sake of her child, has furnished the factor necessary to tip the scales in favor of her ultimate recovery. Such experiences tend to create in the mind of the surgeon the impression that there are some patients who, under certain circumstances, simply will not give up, and who "refuse" to die, when according to all the rules of the game, as generally understood and played, they should do so, since apparently everything was against them, save only the will to live. Kipling gives expression to this same idea in his well known poem, "If."

"If you can force your heart and nerve and  
sinew

To serve your turn long after they are gone,  
And so hold on when there is nothing in  
you,

Except the *Will*, which says to them "Hold  
On!"

But there is a reverse side to the picture, one not so well recognized, perhaps, but none the less definite. Unfortunately, all patients are not so constituted as those to which we have been referring. Just as we occasionally see a patient who is determined to live, so there are others—fortunately comparatively few in number—just as determined to die, and who are seemingly content to lie down and die without a struggle. In this connection, I recall the remarks of a surgeon of wide experience, under whom for a time it was my privilege to work as assistant. Upon one occasion, in referring to a certain operation that he had performed on a female patient of this latter type, he characterized her mental attitude rather graphically and perhaps a bit resentfully, thus,—"We did a good job on that woman if I do say so, now didn't we, Finney?" To which proposition, I heartily assented. "But," insisted he, "damn her, she didn't do her part, she didn't back us up." This determination upon the part of the patient to do his or her part after a surgical operation, is one of the most heartening assets that a surgeon can have in his work, and it can and should be encouraged by him. Surgeons

are but human—very human in fact—and as such respond to certain mental stimuli received in the course of their professional work. Every one of us recognizes the fact that he can not do his best work when he well knows that the case upon which he is about to operate is hopeless to start with. Under such circumstances he is beaten before he begins. While on the other hand, the spirit of optimism and cooperation upon the part of the patient about to be operated upon is infectious, and the surgeon is thereby stimulated to put forth extraordinary efforts in the patient's behalf.

As we have already indicated, the belief is very prevalent that in some mysterious way mind exercises a marked control over matter, that at times, by the sheer force of will power, apparently insuperable obstacles may be overcome, and the seemingly impossible accomplished. One could multiply instances of this controlling influence of the spiritual over the material in all walks of life. Military history is replete with the records of heroic deeds performed under its magic spell, such, for instance as Horatius at the bridge before Rome (every school boy, certainly of fifty years ago, will remember declaiming the stirring poem recounting this valorous deed); Washington, at Valley Forge; Joan of Arc; and more recently, Petain at Verdun, he of "ils ne passeront pas" fame. In the realm of science, one recalls the many wonderful accomplishments by devoted workers and investigators, many of them achieved in the face of untold difficulties and discouragements, not to mention dangers and death itself. The field of sport furnishes many examples. I shall refer to but one. The late Bill Roper, the great Princeton football coach, capitalized this idea in his famous text—"The team that won't be beaten can't be beaten," from which he preached many a stirring sermon to his lagging teams. And so one could continue indefinitely relating instance after instance, where, in all forms of human endeavor, an indomitable will has repeatedly prevailed over apparently insurmountable obstacles.

On the other hand, instances aplenty are on record where patients have died without any discoverable reason, other than the preoperatively announced determination so to do. Of course, everyone recognizes the fact that in

*every* case the subject of the obsession either to die or get well, as the case may be, does not do so, but it happens with sufficient frequency to attract attention as something more than a mere coincidence. This obsession or presentiment or will to die, call it what you like, not infrequently has its origin in a dream or some previous psychic experience that has, perhaps subconsciously, made a profound and lasting impression on the patient. It may be, however, and not infrequently is, associated with an approaching surgical operation. Everyone is familiar with the characteristic actions of certain persons of a highly nervous temperament, who, when told that a surgical operation is necessary—to use a very expressive slang phrase—at once “hit the ceiling” and along with other evidences of emotional excitement, vociferously proclaim that they will die as a result. This type is readily recognizable and makes little impression upon the surgeon. That other type, however, to which I wish to call your especial attention, is quite different. Here the patient is self-contained and free from excitement. He or she will look you straight in the eye, listen quietly to your opinion and advice, and then calmly remark that of course, if you think he should be operated upon, he will have it done, because he respects your judgment and has confidence in you, but that if operated upon, he knows that he will surely die. To such an one you can say or do nothing to disabuse his mind of this fixed idea until you have taken the time to gain his confidence and reason it out with him. There is a wide-spread belief among surgeons, founded upon experience, that such a patient is more than likely to carry out his announced intention, unless some well-directed effort is made to obviate it. Personally, I no longer operate upon this type of case, until I have had him or her under observation for a long enough time—it may be weeks—to completely gain his confidence, and come to know him, and not always do I operate then.

This curious type of individual just described, every surgeon of experience will meet with now and then, fortunately not often; but having met him once or twice, he will not be apt to forget him.

Although it was many years ago, very early in my professional career, I have a very vivid recollection of the first case of this kind that I

had seen. I was consulted by a middle-aged maiden lady, of the quiet, rather shy type, referred to me from the country. Her complaint was an abdominal swelling, which upon examination proved to be an ovarian cyst. Not doing gynecological work, I referred her to a gynecologist, who advised removal of the cyst, at the same time assuring the patient that the operation would be a simple one, and attended with little risk. She returned to me after his examination to talk matters over. She said that she would of course take his advice and have the operation, as she fully realized that something would have to be done, but that she would have to return home first to arrange her affairs, since if she were operated upon she was sure that she would die. I tried to disabuse her mind of this idea, but was unable to do so. She returned home and after two weeks was back again. I happened to be in the hospital (Johns Hopkins) when she arrived, and accompanied her to the ward. It was a hot, sultry summer afternoon, and there was in progress just at that time, a severe electrical storm. As we entered the ward to which she had been assigned, there came a blinding flash of lightning accompanied by a deafening crash of thunder. She stopped, and without the least show of agitation or fright, quietly remarked “that settles it!” “Yes”, said I, “it certainly seemed to settle something.” She replied, “Oh you don’t understand what I mean. Now I know that I shall surely die if operated on.” An omen direct from Above, so she had interpreted the occurrence. It then developed that the ward we had just entered had been struck by lightning and set on fire. There was considerable excitement as a result, but no great damage had been done.

Careful physical examination of the patient before operation was negative, except for the ovarian cyst. A day or two later, she was operated upon, still insisting in her quiet way that she would die as a result. She took her anesthetic well. The operation, which consisted in the removal of a simple, uncomplicated ovarian cyst, revealed nothing unusual, and was quickly and skillfully performed. She recovered promptly from her anesthetic and made fairly satisfactory progress for a day or two. In reply to questions, she said she felt very weak, and continued to insist that she would not recover. She gradually failed, be-

coming progressively weaker, for no apparent reason except failure to retain and assimilate nourishment, and responding not at all to treatment. She was seen, among others, by Doctor Osler, who called her condition, "anorexia nervosa." Now we would probably call it acidosis. In less than a week's time she died. No complete autopsy was allowed, but the operative wound was reopened and thoroughly explored. Everything was found to be all right. Cultures from the abdominal cavity were negative. No adequate cause of death could be assigned.

I will report one more case. A middle-aged traveling man whose home was in a southern city, consulted me for an inguinal hernia which on several occasions had become temporarily incarcerated, and had thereby caused him no little inconvenience and mental worry. He was of a rather nervous temperament, but quiet spoken, and not given to extravagant statements. I examined him and owing to his past history and the nature of his occupation, advised a radical cure. He replied that he was sure that operation was necessary, and that he had made up his mind to have it done, if I so advised; but he rather casually added, that if operated upon, he was sure that he would die. Impressed by his manner, and as a result of previous experience with this type of case, I questioned him closely about his obsession, which apparently it was. He told me that he was not willing to wear a truss, that he had tried it; that it was extremely objectionable; that it did not hold the hernia satisfactorily; that he had thought the matter through, and felt that he could not go on as he was; that the operation was the only thing to do, but he continued to insist that if he were operated on, he would surely die. Further impressed by his earnest manner, and the frank way in which he looked me in the eye, and reiterated his conviction, I declined to operate and sent him home, after directing him where to go to get a properly fitting truss, and urging him to continue to wear it. After some months, however, he returned, saying that he could no longer wear his truss, and that he was back, ready and determined to have the operation. In reply to questions, he still insisted that he felt the operation was necessary, and that he wanted me to do it, but he was still sure he would die as a result. Foolishly

I consented to perform the operation, after trying without avail either to dissuade him, or "to pass the buck" to someone else. With some misgivings, I admitted him to the hospital. The report of his pre-operative physical examination was entirely satisfactory throughout. The operation was a perfectly simple one in every way, and he had an uneventful convalescence, except that for several days he ran a slight unaccounted for elevation of temperature. Phlebitis was suspected, but no physical signs could be found. I joked with him a bit, after a day or two, about his surprise, which he admitted, at still being alive, but was always met with the same quiet rejoinder, that he wasn't yet out of the hospital, so we had better wait awhile. After the usual period of ten days, his wound having completely healed, and his temperature having subsided, he was ready to sit up, and apparently was beginning to become reconciled to the idea of living; when suddenly while on the bed-pan, without warning, he uttered a cry, put his hand to his chest, and died. Unfortunately, no autopsy could be obtained, but owing to the character of the attack, and the slight elevation of temperature noted, it appeared most likely that his death was due to pulmonary embolism or possibly coronary thrombosis. It was learned later that during the interval between his two visits to me, he had arranged all of his affairs, made his will, bought a lot in the cemetery, selected his pallbearers, arranged all details for his funeral, including the engagement of the clergyman to conduct the services, the purchase of a new suit of clothes in which to be buried, and which he had brought along with him when he returned for his operation. He also left a note giving full directions for the funeral and the disposal of his effects. All this showed how firmly the idea had taken possession of him.

Dr. R. L. Payne of Norfolk, Virginia, relates a case in point. The patient, a woman of a rather nervous type, had a simple uncomplicated hernia. Into the ward where she was a patient, there was admitted the day before her operation, a mildly insane woman, who when she heard that this patient was going to be operated upon, kept repeating to her that she was going to die, that the surgeons were going to kill her, that there was no doubt about it. The next morning when she was



put on the stretcher preparatory to be taken to the operating room, the insane woman rose up in her bed and, shaking her finger at her cried out: "You are going to hell right now; they are going to kill you." The woman went to the operating room greatly agitated by this tirade, and died soon after a simple, uncomplicated femoral hernia operation. The autopsy revealed no demonstrable cause of death.

What is to be done in case one is consulted by a patient of the type just referred to, who is really in need of a surgical operation, as were the two cases just reported? My respected former chief, Professor Halstead, would not operate upon any patient with the "I shall surely die if operated on" complex. For years, until comparatively recently, I have consistently declined to operate upon such cases when recognized. A number of my surgical friends tell me that they do the same thing. I believe, however, that in selected cases, it may be possible, if one is willing to take the time and trouble to gain the patient's confidence, as to be able to reason the obsession out of his mind, and thus make him or her, an ordinarily good surgical risk.

I have recently operated upon a case of advanced exophthalmic goitre; a woman of middle age, in otherwise good condition. She had lost her husband a year or two ago, and had since been much depressed and discouraged. In the course of her examination she stated that she knew that she would have to be operated upon, as she couldn't carry on as she was and added that she was ready but that if operated upon, she would surely die. I discussed this idea with her and then declined to operate, unless she would come into the hospital prepared to stay as long as I wanted her to, until I made up my mind whether or not to operate at all. She agreed to do this, as she had nothing to do, and entered the hospital. I was interested to see what I could do with her, so I saw her every day and discussed with her the operation and everything pertaining to it, for about four weeks. At the end of this time her "I will surely die" complex had entirely disappeared; she was cheerful and quite reconciled to living. The operation was most satisfactory in every way, and she went home well, with an entirely new outlook on life.

Gould and Pyle in their book, "Anomalies

and Curiosities of Medicine," Philadelphia, 1897, state "presentiment or divination of approaching death has been established as a strong factor in the production of a fatal issue in many cases in which there was every hope on the part of the attending physician for a recovery." Hippocrates, Romanus, Moeller, Richter, Jordani and others of the older writers all mention it, and certain later writers, Andrews, Vos, Montgomery, et al, have reported cases. The last named reports the case of a woman suffering from carcinoma of the uterus. He saw her first on October 6. She then told him that she had a strong presentiment that she would die on October 28. That was the date of her birth, and her first husband had died on that date. On that date, too, she had married her second husband. On October 27 her pulse began to fail without adequate cause; she became progressively more prostrated, and died on the 28th. This case well illustrates the association of presentiment and anniversaries with the death of the patient.

Dreams seem to have a potent influence in some cases, many instances of which are recorded. I will relate just one, reported by Montgomery: The patient was a married woman, aged forty years, mother of several children. He was called to see her early one morning, because of great nervous agitation and distress due to a dream from which she had just awakened crying. Beyond the extreme distress and nervousness, no evidence of disease of any kind could be found. Her dream consisted of seeing in a churchyard a handsome monument. It had been erected by some children to the memory of their mother. Upon observing the children who were standing around it, they appeared to be her own, and upon closer inspection the monument was seen to be hers, with her name inscribed on it. Montgomery states that, after talking to and reassuring her for a while, she became more composed, and fell asleep, but presently awakened much as before. Again, most careful examination revealed no evidence of disease of any kind. After a few hours, the uneasiness and depression returned, the pulse grew weaker, and in a few hours more she died. No report of autopsy.

Andrews in discussing this peculiar condition, after several experiences with it, re-

marks: "Presentiment of death is a dangerous symptom, and one which should never be disregarded."

It is an interesting fact that certain well known historical characters have been subjects of this premonition,—Mozart wrote his immortal "Requiem", convinced that it would be for himself. Just before his death, which occurred shortly after its completion, he remarked: "Did I not tell you?"

Hogarth possessed with a similar premonition hurriedly painted the canvas which he declared was to be his last. When it was finished, he broke his palette to pieces and said "I have finished." Shortly afterward he died.

A number of instances have been brought to my attention from the World War, where soldiers have met their deaths in battle, subjects of a strong premonition.

In explanation of these and similar premonitions, so great an authority as John Hunter is quoted as saying: "We sometimes feel within ourselves that we shall not live, for the living powers become weak, and the nerves communicate the intelligence to the brain." Hunter's own death seems to have been a confirmation of this statement, for on leaving home to attend a faculty meeting, he intimated that if a certain discussion which awaited him at the hospital to which he was going, took an angry turn, it would prove his death. While speaking a colleague flatly contradicted him and in a rage he expired almost immediately. Of course in Hunter's case there was ample cause for his death. He was known to have an aortic aneurysm, supposed to have resulted from syphilis with which he had inoculated himself for experimental purposes. He had also been subject to recurring attacks of angina pectoris, but unquestionably his death was precipitated by the fit of anger described.

Gilbert, in *The Romance of the Last Crusade*, the description of Allenby's march on Jerusalem, states it as a well known fact that Arab camel drivers accustomed to the heat and sands of the desert, when they felt that they could no longer stand the cold and the rocky traveling in Palestine, bade affectionate farewells to the camels they had been driving, then went off to the side of the road, carefully selected a spot, squatted down, pulled the skirt of their cloaks over their

heads, murmured a prayer to Allah, and very shortly afterwards they would be dead. Having made up his mind that he was unable to continue further, too sick and miserable to live, the driver just "willed himself to die." Gilbert relates the case of a native, his own body servant, who had been brought before him for some small crime he had committed. A minor punishment was awarded. However, the native insisted that he was not guilty and requested a remission of the penalty, which was refused; whereupon he replied with dignity, "my master does not believe me, therefore I shall die." Some hours later the man was found just outside the camp, under a palm tree, dead. After having in the customary manner carefully wrapped his cloak around his head he had "willed himself to die." Returned medical missionaries and others from the Far East corroborate these reports, and record similar incidents in their own experience.

I am indebted to my friend, Doctor Charles F. Elvers, who is quite an authority on the life and customs, ancient and modern, of our American Indians, for the statement that among certain tribes, when the Spirits "called" an individual, his life was ended and he straightway lay down and died.

Says John Reid in his book entitled *The Philosophy of Death*: "Death is not infrequently ascribed to mental states such as fright, joy, grief, a broken heart, etc. However, in all such cases if there is any tendency in the system to any particular disease, the probability is that the intense mental emotion will at least accelerate its course, and thus bring about the death of the individual."

That there is something in this idea, there has, I believe, accumulated enough credible evidence to make it at least quite probable. But let me again utter a word of warning: It does not do to be too positive in matters incapable of scientific proof. That such a thing as a measure of voluntary control over one's vital forces by certain individuals, especially among the more primitive races, under certain circumstances, numerous reports of well authenticated cases would seem to indicate. Hence I repeat: the careful surgeon would do well, before deciding upon a surgical operation, to examine into the mental atti-



tude of the patient as thoroughly as into the state of his physical health.

The object of this paper is to bring to the attention of physicians and surgeons the advisability of having the patient, about to undergo the trying experience of a surgical operation, in as good condition, both physical and mental, as possible. When a surgeon undertakes to operate upon a patient, it is fair to assume that he accepts the responsibility of seeing to it that all means in his power will be exhausted in order to bring about a good result. Heretofore, attention has been directed chiefly to the strictly physical aspects of the case largely to the exclusion of the mental. I wish to enter a plea for a more careful study of the mental and emotional state of the patient. From time immemorial it has been known that mind exercised a most important influence over matter. But in some way this fact has been largely disregarded in surgery. By this report of several rather interesting cases that have occurred in my own personal experience, and by the study of similar experiences of others, illustrative of the point it is desired to make, it is hoped to draw the attention of the profession to the important effect upon the ultimate result of a surgical operation, of the mental state in which the patient is at the time of the operation. My experience covering a half century and a little more in the study and management of surgical cases, has impressed upon me the fact that the matter is of sufficient importance to bring to the attention of the profession for further observation and discussion.

From this rather long and disconnected recital, the following conclusions would appear to be justified:

1. That closer attention should be given by surgeons to certain imponderable but, nevertheless, important factors that may vitally concern the success or failure of a surgical operation.
2. This is made obvious by the undoubted fact that the psychic element may at times exert a far-reaching influence over the physical well-being of the individual.
3. That much can be done in the way of mental and physical relief for patients both before and after operation, thus rendering them better surgical risks.
4. In order to accomplish this, the surgeon must be willing to take the necessary time and trouble to study and know his patients, in order to secure their wholehearted confidence and cooperation. In other words he must be a student of human nature. He must learn to know and respect the mental and emotional elements in his patients.
5. It is well recognized that much that is referred to in this paper is as yet incapable of scientific proof. It is submitted largely as a matter of interest, without any idea of drawing too definite conclusions therefrom, but with the firm conviction that there is enough in the observations reported to warrant further careful study by surgeons and physicians.
6. Finally the point that I have had in mind in the preparation of this paper, and the one that I would like to leave with you is: In all of our professional work let there be no whit less of the scientific but I plead for more of the human element, more heart in all of our relations with our patients. They will thus fare better, and we will have more real satisfaction in our work.

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## PROTAMINE ZINC INSULIN IN THE TREATMENT OF DIABETES MELLITUS\*

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This paper on protamine zinc insulin is based on the clinical conclusions of others as given in the literature and also on our own experience with 37 private patients. Seventeen of these have been transferred from old insulin routine and 19 had received no previous insulin treatment.

Protamine zinc insulin as sold on the market today is made up of insulin hydrochloride, protamine and small amounts of zinc. The zinc content is 0.2 mg. per hundred units of insulin. Rabinowitch<sup>1</sup> has shown that there

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is no danger of any cumulative effect of zinc in the body. The protamine is obtained from the sperm of the salmon in this country. Protamine zinc insulin is a relatively insoluble compound and is purchased as a flocculent suspension. Each cc. contains 40 units of insulin. A preparation containing 80 units per cc. will soon be available. Recently we have transferred four of our most severe diabetics to this strength insulin. To date, it has been fully as efficient and satisfactory as the U40. No change in dosage has been necessary. To insure uniform dosage, the vial should be gently shaken each time just before use. The preparation is quite stable and will keep for six months or longer. It is buffered so that it is maintained at a pH of 7.3 which is the point of lowest solubility of the compound. This pH is only slightly below that of tissue fluids. It has been found that the addition of zinc adds to the stability of the preparation and prolongs its activity after injection. As with most biological products, it is best kept in a cool place.

Protamine zinc insulin never should be given intravenously. Its effect on sugar metabolism is the same as that of regular insulin except for more prolonged action. Clinically, the effect of protamine zinc insulin is noted three to four times as long as when old insulin alone is used. It must be remembered that each dose of new insulin acts for more than 24 hours, that it does not take effect immediately after its injection and that it is somewhat cumulative in its action. Richardson<sup>2</sup> has shown that 90 minutes after injection it will lower the blood sugar only 12 per cent. The full effect is not noted until about 6 hours after injection. This continues for about 12 hours or more and then the curve of activity gradually decreases. Various experiments (Lawrence and Archer)<sup>3</sup> have shown that this compound will act longer when no carbohydrate has been given, and on the other hand frequent large carbohydrate feedings will lower the period of its activity.

Protamine insulin is injected in the same manner as old insulin. It is wise to instruct the patient to use a new site each day. Convenient areas on either thigh can be mapped out for consecutive use. There is less tendency to dystrophy because of the non-acidity of the preparation and the need for fewer injections each day. Local reactions occasionally occur

at the site of the injection but there are no other ill effects. After a few days or weeks, local reactions gradually cease. The syringe may be boiled before use each time or may be kept in alcohol. Joslin<sup>4</sup> states that the small amount of alcohol left in the syringe has no ill effects. If old insulin is to be given also, it must not be mixed with the protamine insulin. The old insulin may be given first or the syringe washed out and the old insulin then injected. This is because the protamine left in the syringe will precipitate some of the old insulin and the quick action of the old insulin will be lost.

The time of administration varies somewhat with many clinicians. Sprague,<sup>5</sup> Joslin,<sup>6</sup> Wilder<sup>7</sup> and many others recommend the morning as the preferable time for administration. We advise morning injection for most of our patients. This is not only the most convenient time for the patient but also makes the fasting blood sugar and fasting urine the guides as to the adequacy of the protamine insulin dosage. This also allows the maximum activity of protamine zinc insulin to be placed at the time of the heaviest carbohydrate intake. We suggest, for the sake of routine, a definite time for each morning dose, usually seven or seven-thirty o'clock. Some variation of the breakfast hour is permissible but it should be within one hour after taking protamine insulin. When a patient must take both old insulin and protamine insulin, Joslin<sup>4</sup> suggests that both be given at the same time but separately, and they should be given within 30 minutes of breakfast. As a rule, we have had a set time for protamine insulin injection and then had the patient take the old insulin just before eating breakfast. Old insulin is given for its quick action to cover the hyperglycemia that follows meals. This occurs most frequently after breakfast and dinner. Usually, by giving a dose of old insulin before breakfast the blood sugar is kept near normal until the protamine insulin has had time to take effect and hold it at that level. If the old insulin is given too soon before a meal, it may precipitate a reaction. Joslin quotes Himsworth as stating that he has been giving protamine insulin each night at 11 o'clock with excellent results. This might well bear further watching.

The diets we use are taken from the Joslin

cards and are moderately high in carbohydrate. Our average diet contains about 150 Gm. Campbell<sup>8</sup> feels that the best results are obtained with lower carbohydrate diets. Joslin<sup>6</sup> believes that protamine patients do better on a carbohydrate diet averaging slightly less than 150 Gm. When the patient is receiving new insulin in the morning, the diet is best divided so as to allow  $1/5$  of the carbohydrate for breakfast,  $2/5$  for dinner and  $2/5$  for supper. Meals should be distributed over as near a 12 hour period as is practical. Should there be consistent glycosuria after a given meal some of the carbohydrate can be taken from that meal and be given mid-way between it and the next meal or just before going to bed. The latter feeding time is particularly desirable when there is a tendency to hypoglycemia during the night. Should the patient feel as though a reaction were coming on when he gets up in the morning, he should be instructed to take his fruit then instead of waiting until breakfast.

Wilder,<sup>9</sup> Rabinowitch<sup>1</sup> and others have shown that protamine insulin is of definite value in the treatment of acidosis or diabetic coma but should be used only to supplement regular insulin. From 50 to 100 units should be given immediately and the patient then treated as though he had received no protamine insulin. The latter should be repeated again in 24 hours. Control of the acidosis is thus accomplished more quickly and with less old insulin. We have used it in diabetic coma with very satisfactory results and feel that it should be given in diabetic acidosis.

The severely diabetic patient without acidosis should be put on new insulin unless he has been doing well for years on old insulin and does not wish to change. If the transfer is to be made, additional small doses of old insulin often will be required. To establish the dose of protamine insulin for the new patient with severe diabetes, it is well to be governed by the fasting blood sugar. As an example, the patient with a blood sugar of about 500 mg. can be given 50 units each morning and after two or three days if the fasting blood sugar is still elevated the dose should be raised four to ten units each day until the early morning urine is negative for sugar. When the fasting blood sugar becomes normal, the protamine insulin dosage has been established. If

the patient continues to have glycosuria after meals, a small dose of old insulin will usually render the urine sugar-free. This glycosuria most frequently occurs after breakfast, but by noon the protamine insulin should control it for the balance of the day. If this dose of old insulin fails to control the glycosuria, another small dose may be given before lunch. In this instance, the dose of old insulin should be increased the next morning. Caution should be used if old insulin is given before supper. If the blood sugar falls too low in the early evening, the patient will probably have a reaction in the early morning due to the continued action of the protamine insulin given the previous day. The urine voided between bedtime and breakfast is a good guide as to adequate protamine insulin dosage. If there is sugar in this specimen, it is best to have the patient void again before breakfast and test this specimen as some of the sugar may have been carried over from the previous evening. It should be remembered that urine voided just before each meal may contain sugar which was excreted in the first hour following the preceding meal. If the patient voids again a short time later, the second specimen will often be negative.

Most of the moderately severe diabetic patients may have to be taken care of in the manner just described; however, the majority of these patients will get along nicely on protamine insulin alone. Joslin<sup>6</sup> and Marble<sup>10</sup> consider good control to exist when the patient's blood sugar is never above 200 mg. per hundred cc. of blood and when there is a normal fasting blood sugar.

The mild diabetic patient who is well controlled by diet need not be placed on insulin, but the patient who occasionally gets a hyperglycemia is probably better off on from ten to fifteen units of protamine insulin daily. Joslin<sup>6</sup> suggests that this will save many mildly diabetic patients from progressing and that some patients will sufficiently improve to omit insulin therapy. If a patient needs only one small dose of old insulin, he is probably better protected by the same amount of protamine insulin.

Many methods of transferring a patient from old insulin to protamine insulin have been advocated. They are all more or less similar. It is best to have the patient in the



hospital for transfer because time is saved and close observation lessens the chances of severe protamine insulin reactions. If the patient is well stabilized, the dose can be directly substituted. That is, the same number of units of protamine insulin is given before breakfast as the total daily dose of old insulin had been. A marked glycosuria can be expected for the first two or three days but the urine will then gradually clear up so that at the end of a week or two it may be necessary to reduce the dose. Some clinicians begin protamine insulin therapy with an amount equal to about  $2/3$  of the total daily dosage of old insulin and then increase it as necessary. Joslin<sup>6</sup> suggests giving the usual dose of old insulin before breakfast and also a dose of protamine insulin equivalent in units to the amount of old insulin previously taken during the balance of the day. The protamine insulin dosage is gradually increased and the old insulin dosage lowered. By giving old and protamine insulin at the same time, glycosuria can be largely avoided and control maintained. Also, the patient does not have to be observed in the hospital as long. The method we have found quite satisfactory is to directly substitute the total number of units of old insulin with new insulin. This is given in the morning before breakfast. Simultaneously the same dose, or slightly less, of old insulin that the patient had been receiving before breakfast is also given. The doses of old insulin that had been given later in the day are omitted. If no marked glycosuria has occurred, the dose of old insulin is reduced about 50 per cent the following day and again is reduced or omitted the morning of the third day. During this time, the protamine insulin dosage is maintained. Usually a fasting blood sugar is obtained on the morning of the third day and if normal or below normal, the protamine insulin is reduced accordingly. Subsequent blood sugars are obtained every three to seven days until the patient is well stabilized. In the interim between blood sugars and until the patient is well controlled, we have the urine from four periods of the day examined for sugar and acetone. These periods are from breakfast to lunch, lunch to supper, supper to bedtime and bedtime to breakfast. Whether the patient will have to take both kinds of insulin depends upon how well the glycosuria

is controlled without old insulin during the day.

Hypoglycemia resulting from protamine insulin is quite different from that arising from old insulin. The reaction is usually insidious and is characterized by drowsiness, headache, nausea and fatigue. As the hypoglycemia progresses, numbness and tingling may occur. If not combated, coma may ensue. The earliest symptom our patients have complained of has been headache. This is usually dull, diffuse and associated with a peculiar fullness in the head. Hypoglycemia in most instances occurred between the hours of 1:00 and 7:00 a. m. and more often near 7:00 a. m. The blood sugar is considerably lower than when old insulin has precipitated the reaction. Two of our severely diabetic patients who had just been transferred to protamine insulin had a blood sugar of 30 mg. before showing any marked symptoms. Two others who had reactions became mentally confused and later unconscious. They did not complain of headache until after the hypoglycemia had been controlled.

Hypoglycemia will occur if unusual physical exertion is carried on for any length of time. If the patient plans a game of golf or some similar activity, he cannot depend upon reduction of that morning's dose of insulin because the protamine insulin taken the previous day will still be acting. Fruit flavored life savers each contain 2.5 Gm. of carbohydrate. The patient should be advised that if any unusual symptoms occur, one of these may be taken every 30 minutes until symptoms are relieved or until the next meal is eaten. Should a mild reaction occur during the night, we advise the patient to take a glass of milk and two Uneeda biscuits. This allows a slow absorption of carbohydrate and tends to prevent recurrence until time for breakfast. If the reaction is severe, we give orange juice or syrup and follow this with Uneeda biscuits as often as needed. If the patient is comatose, intravenous glucose treatment may be necessary. If the patient has been in reaction for a long period of time it should be given slowly as there may be danger of petechial hemorrhages in the brain. A long period of hypoglycemia, even though symptomless, is not without danger. Exercise is as important as ever, but any undue exercise

usually requires an intake of small amounts of carbohydrate to protect the patient.

A diabetic patient should carry an identification card stating his name and address and his usual dose of insulin. The well controlled and instructed diabetic patient taking protamine insulin rarely has reactions and as a rule needs less change in his routine than does the patient on old insulin. Protamine zinc insulin has been proved to be an invaluable advance in the management of the diabetic patient.

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#### SQUINT\*

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In presenting this paper, I am seeking to help bring the general medical profession abreast of the times in the matter of squint. Thirty-four years ago, Claud Worth wrote in the preface of the sixth edition of his book *Squint*: "The first edition of this book was not published until 1903, when I thought I could be certain of what I said."

Since that first edition in 1903, only insignificant additions have been added to the amaz-

ing work of that remarkable Englishman, Claud Worth. And yet here in America, thirty-four and a half years later, we find many of the members of the general medical profession, and some oculists, in rather profound ignorance of Worth's work.

What I have to say, therefore, is nothing new. I will especially avoid controversial aspects of the subject and seek only to drive home a few essential, thoroughly established principles, in ignorance of which no medical man should remain.

Approximately one out of every forty children have a strabismus; about nine out of every ten cases of strabismus are convergent cases; and about eight out of every ten cases of convergent squint belong to what I shall call the classical group. This classical group, then, contains about three-fourths of all squints. Let us, therefore, address our attention to this group. It is by far the most important, because it is the group where proper treatment in early childhood is so effective.

The classical case, as it is seen today, may be said to present three ear-marks. These are: a crossed eye, a blind eye, and an alibi. The child has one eye which turns in. This eye will be found to have defective vision, often amounting to virtual blindness for central vision, and the parent will have the alibi, usually the history of chickenpox, measles, or a "lick" on the head. Never mind the alibi; let's consider this cross-eyed child. *Why* does the eye turn in? It turns in for one main and one or more auxiliary reasons. The main reason is that the fusion faculty was faulty, not absent, from birth. The auxiliary reason is usually a high refractive error. Especially is this true when one eye differs markedly from the other. Considerable hyperopia is usually present. Thus, when the eyes seek to accommodate sufficiently to see (in the presence of hyperopia, remember), the stimulus to converge is greater than the need to converge, and the faculty of fusion being weak, one eye, usually the one with the greatest refractive error, swings in.

Once the eye is in, it is clear that double vision will be experienced unless one eye shuts off its vision. This the squinting eye proceeds to do. This shutting off of vision is an intriguing and subtle business, but what we are

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concerned with here is the fact that if somebody doesn't do something about it, the vision of that eye will be irretrievably lost by the time the child is 7, 8, or 9 years of age, varying with each case. And here we come to the crux of the matter, for there are abroad in this country two very wrong ideas. The first of these is that when squint is found in a child of 2, 3 or 4 years, the child if let alone may "grow out of it." He may indeed grow out of it, in one of two ways, either through spontaneous recovery, which is rare, or by the squinting eye becoming so blind that it will swing almost straight again. Let me amplify this. In its early stages, the squinting eye tends to turn far inward to avoid the most disagreeable aspect of diplopia, namely, proximity of the two images. Then as loss of vision progresses, the need to turn so far inward is reduced, and the eye comes to take up a more natural position, which is looking straight ahead. The child is regarded by its parents with gratification, as "growing out of the squint." To the unpracticed observer, the eyes may appear straight, and all is well until a school test turns up a blind eye, and it is too late to save much of the vision.

The second very wrong idea is one which many medical men have unfortunately held and perpetuated, namely, that squint patients should be let alone until 7, 8, or 9 years old and then operated upon. This dates back to the 1890's, when amblyopia ex anopsia was not known to be a curable condition.

In the modern (since 1903) treatment of squint it is considered that a three-year-old patient is twice as easy to cure as a four-year-old patient, three times as easy as a five-year-old patient, and ten times as easy as a seven-year-old patient. In the case of a patient of nine years, about all we can usually do is to operate to straighten a more or less blind eye for cosmetic effect.

How do we treat these little fellows? That is a long story, but the principles are simple. First, we refract them. Under atropine, with a retinoscope, it is no trick at all to refract a one-year-old to within half a dioptre,

which is quite close enough. A four-year-old can be refracted to a quarter of a dioptre with ease, if there is any cooperation. Having refracted the case, the proper glass is put on the blind eye and the good eye is occluded, totally and constantly, until vision is restored as much as possible to the blind eye. The occluder is then replaced by the proper lens for the good eye, and with more or less fusion training (not muscle exercises), the eyes in over one-half the cases will come straight. In the remaining cases, surgery will have to be resorted to and should be done at the age of 4 or 5 years, sometimes at three years if occlusion, glasses, and fusion training have failed after adequate trial to produce a cure.

Thus we see that the treatment of squint should all be carried out before the age of seven, and that "waiting to see what will happen" is the worst of all policies. If you have a patient whose parents insist on waiting for one reason or another to have the proper examination, try to persuade them at least to occlude the straight eye in the meantime. The more the child resents this occlusion, the more he needs it, for the reason he resents occlusion is blindness in the remaining eye.

I will pass from this sketchy presentation of the "classical" group only to mention that the remaining one-fourth of squint cases is made up of divergent cases, true alternaters, muscle anomalies, and miscellaneous baffling squints. These are all difficult cases but I offer you the consoling thought that the difficulty is not yours. Neglect of these cases in early childhood usually does little if any harm. "Waiting" is often a good policy. Glasses are frequently contraindicated and the general physician can remain in the most profound ignorance of the whole subject without doing these patients any particular harm.

In closing, I would like to invite discussion of the "classical" group to the end that we may clarify the simple but important principles underlying the necessity for the earliest possible treatment of this group.

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## OLD COMPRESSION FRACTURES OF THE SPINE\*

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It is my purpose in this paper to confine myself principally to old compression fractures of the spine. The reason for this is that it is not rare to find these patients coming for relief of various symptoms due to compression in which the fracture was not recognized at the time of injury.

It is my belief that rarely should compression fracture of the vertebrae present delayed symptoms and if this occurs usually the patient or the physician is at fault. Either the patient did not present himself for examination or the examination by the physician was not complete. Some of the back injuries in which fractures of the body of the vertebrae occur are so slight that sufficient attention is not paid them by the patient to cause him to seek medical aid. Too often, however, in spite of examination by a physician the condition is not diagnosed because of failure to make use of the x-ray. Any injury such as a fall, giving rise to localized pain and tenderness in the spine, especially the lower dorsal or upper lumbar, should have the benefit of an x-ray examination.

Of course, injuries with cord lesion are not the ones overlooked because they give rise to immediate symptoms. We must not forget that sometimes a surprisingly slight injury may cause compression fracture which, if properly treated, will cause no concern; but if left untreated may give rise to permanent injury with associated annoying symptoms and even disability. It is unfortunately true that compression occurs later when there was no x-ray evidence at time of injury.

Kummell in 1891 first described a condition resulting from spinal injury, giving rise to definite pathologic changes, which he termed a "rarefying osteitis of a vertebra." He described the lesion as of traumatic origin, such as a blow on the shoulders, the back of the neck, or the top of the head with a resulting pressure or squeezing of one of the mid ver-

tebrae with no gross fracture. The injured individual does not experience localized pain in the back at the time. After two or three days he begins to complain of back pain, which sooner or later disappears for a time, again to return months or years later. At this time there may be symptoms of a neurological nature such as a pain in the back, radiating down the legs or around the intercostal nerves causing girdle-type pain. There are three stages of this condition: first, the occurrence of the injury, often of a minor nature with no symptoms of a fracture nor x-ray findings of such; second, a period in which there are no symptoms of any type—a period of well-being; third, usually after several weeks, months, or even years, the gradual development of back pain, accompanied by neurological symptoms. There may be knuckling of the spine at this time. This may continue until there is cord injury with paralysis. X-ray now shows true compression of the vertebrae.

The earlier the diagnosis is made and proper treatment instituted, the fewer will be the symptoms. In the true Kummell's disease, as stated above, the x-ray at the time of injury will be negative; recheck at a later date will be necessary to make the diagnosis.

The ever present legal involvement makes it important to know of these injuries. If x-ray at the time of injury shows a fracture, the roentgenologist can say definitely whether the fracture is recent or not. On x-ray several months after injury he may be unable to definitely state the time of the fracture. For example, a man may have suffered a compression fracture of the vertebrae several years in the past and have had no particular symptoms. Should he now have any kind of fall or trauma to the back, all subsequent pain and pathology will be attributed to the recent injury instead of to the one suffered several years previously. However, if an x-ray is made at the time of this latter injury, the diagnosis of an old rather than a new lesion can be made. A few months later the roentgenologist cannot be so definite.

I wish to report a few cases. In the first two, treatment could almost certainly have prevented the suffering and disability that the patients have for months experienced.

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Case 1. A woman of 40 years of age came to the office January, 1936, complaining of girdle-type pain, vomiting, pain in the back and radiating down the legs. She gave a history of fracture of the lower dorsal vertebrae two years prior to that. She was x-rayed at the time of the accident but other than rest in bed for a week, nothing was done and she had thought no more of the back. X-ray revealed an old compression fracture of the eleventh and twelfth dorsal vertebrae with deep angulation at the site of the fracture. The gastro-intestinal examination yielded no findings of importance. A posterior plaster shell with marked anterior bow was applied. She remained on this for ten weeks and a brace was then fitted. She had no more girdle-pain or vomiting. Except for mild pains in the legs following undue exertion she is free of pressure symptoms. She dislikes very much the brace and occasionally tries to go without it but cannot do so without suffering. It may be that eventually a fusion operation will be indicated.

Case 2. A white woman aged 66, was admitted to the hospital December, 1935, because of pain in lower back, rectum and bladder. The pain in the rectal region was most severe. A peculiar feature of the case was that she was in pain only on standing or sitting. The pain was not exaggerated by defecation. Proctoscopic examination and cystoscopic examinations were negative. During the course of x-raying the colon the discovery was made of an old compression fracture of the first and second lumbar vertebrae. Going back into her history we found that 12 years before she had fallen down the stairs injuring her back. From that date she had suffered with backache increasing in severity as the years went by. During the past three or four years it had been impossible for her to walk more than a block or two because of severe back pain. During the past year the pain in the rectal region had caused her to spend most of her time in bed. The back pain fitted into the picture well enough but it was more difficult to associate the rectal pain with the back injury. However, because of the otherwise

negative findings a posterior plaster shell with marked anterior bowing was applied. Within a week she was free from all pain. She remained on the shell for about 10 weeks and then a brace was fitted and she was allowed to be up. Since then she has been practically free of pain except for one or two short periods when she exerted herself too much or went without the brace. She still keeps the plaster shell and frequently sleeps on it for the comfort it gives.

In contradistinction to the above cases let me report the case of a man, aged 54, who came to the office May, 1934, complaining of pain in the back following a jolt received the day before when the horse which he was riding bucked, causing him to land heavily in the saddle. The only symptom was that of pain in the lumbar region of the spine. X-ray showed compression fracture of the first lumbar vertebra. A posterior plaster shell was used for 10 weeks followed by a brace for three months and then a stiff corset for three months. He has had no symptoms since the first ten days. Without treatment he might very well have developed symptoms of cord lesion from pressure.

Until the past few years it was believed that fracture of the vertebrae healed far more slowly than fractures of other bones. I think that most men now believe that with proper reduction and rest, satisfactory healing does take place. These patients should be put at complete rest for two or three months in a plaster cast or, as I prefer, a plaster shell with an anterior bow. Following this, depending upon the severity of the fracture and rapidity of bone formation, they should wear a brace for from three to twelve months. During this time there will have been bone repair of the fracture, after which they can go without support of any kind. It may be difficult to convince the patient of the necessity of such a lengthy course of treatment. He must be made to realize that a few weeks of restriction followed by a few months of cast discomfort will insure him against a lifetime of back pain and possible complete disability.

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## ABNORMAL BLEEDING IN THE MIDDLE-AGED WOMAN\*

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The etiology of abnormal uterine bleeding throughout the reproductive life of woman always presents an interesting diagnostic problem. It is in the middle-aged group that it assumes its greatest importance.

It seems hardly necessary in addressing an intelligent group of physicians to give the reason for this statement, and yet the fact remains that a large number of these women are still being treated with uterine styptics and other drugs without an adequate examination to determine the etiologic factor. This adequate examination is one that the majority of doctors can make, and if it cannot be made it is the definite responsibility of the doctor to his patient to see that she receives it elsewhere.

Women of all classes today generally recognize the fact that abnormal bleeding is not a physiological symptom of the menopause, and the fear of cancer has been strongly implanted in their minds. Certainly, it is the duty of every doctor who accepts women as patients to relieve or confirm this fear by the proper type of examination.

In discussing this subject no distinction will be made between menorrhagia and metrorrhagia. For all practical purposes both can be included under the general head of abnormal uterine bleeding. The causes of this bleeding may be conveniently divided into three classes: constitutional; functional; and anatomical, according to the classification of Novak. Constitutional causes will not be discussed as they will be discovered in the course of a complete physical examination and their role is, not of great importance in the age group under consideration. This discussion will therefore be limited to functional and anatomical causes of bleeding.

It seems best to subdivide this middle-aged class into the menopausal and postmenopausal group for each one has its special problems and conditions. The postmenopausal group includes those women who have ceased to men-

strate for a year or longer, and then resume bleeding. The age limit may extend beyond what is ordinarily considered middle-age, but will be included in this age group.

### FUNCTIONAL BLEEDING

It may be said that all functional bleeding occurs within the reproductive life of the woman, 50% of all cases being in the menopausal group. Bleeding is considered as functional in origin when no pelvic pathology can be demonstrated and constitutional causes have been eliminated. It is usually not associated with pain and is practically always accompanied by sterility.

The pathologic picture is that of a hyperplasia of the endometrium. There is an overgrowth of the endometrium at times assuming a polypoid appearance. The epithelium is tall and heavy and of the non-secretory type. The most constant pattern is that of the glands. Some are large and cystic and others small, giving them the Swiss cheese appearance as described by Novak. The stroma is increased, compact, and often shows mitotic figures. The cause of this condition is quite constant. The fault lies in the lack of the luteinizing hormone of the anterior pituitary. The ovaries show unruptured follicles and the absence of corpora lutea. The growth phase of the endometrium is being constantly stimulated by an over-production of folliculin and never reaches a secretory phase due to the lack of progesterin. Hypothyroidism is occasionally a factor in the causation of this condition. Hyperplasia itself is not the cause of the bleeding as it may exist with amenorrhea. Investigation by Hartman indicates that the bleeding depends upon the presence of a "bleeding principle" having its origin in the anterior pituitary. In the postmenopausal group, bleeding is occasionally caused by a type of ovarian tumor known as the granulosa cell tumor. The folliculoid elements of this tumor secrete folliculin in the same manner as normal follicular epithelium and produce the same response in the endometrium, causing a hyperplasia. Whenever a hyperplasia of the endometrium is found in postmenopausal bleeding the presence of a granulosa cell tumor should be suspected even though the tumor can not be palpated. Novak and Brawner, reporting a series of 36 cases of

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granulosa cell tumor, found that six cases occurred in the postmenopausal age, and that all of these cases were accompanied by irregular bleeding.

#### ANATOMICAL CAUSES

Carcinoma is by far the most important cause of anatomical bleeding in the middle-aged group. Carcinoma of the cervix is found with about equal frequency in the menopausal and postmenopausal groups. It occurs most often on the vaginal surface of the cervix and is of the squamous cell variety. The bleeding produced is usually slight and spotting in character. Carcinoma occurring in the cervical canal is of the glandular type and, being protected from trauma, bleeding usually occurs later.

About 75% of all carcinoma of the corpus occurs in the postmenopausal group and the other 25% begin during the reproductive life of the woman. The bleeding in carcinoma of the body of the uterus is usually slight at first, but soon may become excessive. Prolonged excessive bleeding in the postmenopausal group practically always means carcinoma of the body of the uterus.

Geist and Matus, in reviewing 182 cases of postmenopausal bleeding, found that 42% of the cases were benign, and 57½%, malignant. The incidence of malignancy in this series is low and may occur as high as 65% in all cases of postmenopausal bleeding, according to other authors.

At any time during the reproductive life the retained products of pregnancy and ectopic pregnancy, rarely chorioepithelioma, must be considered as causes of irregular uterine bleeding. Pelvic inflammatory diseases may be an etiologic factor in the menopausal group, more rarely in the postmenopausal group, but it is not as common as in younger women.

Benign polyps, either cervical or fundal, will produce bleeding in both groups. They may be associated with hyperplasia of the endometrium in which a polypoid growth appears. Intramural and submucous myoma and adenomyoma of the uterus are usually accompanied by excessive bleeding.

Cervical erosions may cause slight bleeding, but the diagnosis of carcinoma must always be seriously considered in any cervical lesion that bleeds easily. Bernstein found hyper-

functional ovarian bleeding in 26½% of 1,101 cases of different types of ovarian tumors. Of all these tumors, 58% occurring in the menopausal and postmenopausal groups were malignant.

Senile vaginitis and endometritis may cause slight bleeding in the postmenopausal group.

The following case is reported to show the variety of pathology that may be found in one patient with postmenopausal bleeding.

#### Case Report

Miss C. K., aged 55, was first seen in my office on February 26, 1934. Her history showed that menses began at the age of 13, were regular every 26 to 28 days, lasted five days, and were average in amount. They had stopped ten years previously, in a normal manner, following which she had no bleeding for five years. For the past five years she had had irregular bleeding, which was slight in amount. There was some leukorrhea between periods but she had experienced no pain or loss of weight. She was admitted to the hospital where a diagnostic curettement was done and specimens sent to a competent pathologist, who reported a hyperplasia of the endometrium.

On September 9, 1934, she was again examined in my office and a small polyp-like mass was discovered protruding through the cervix. This was removed and was diagnosed by the same pathologist as adenocarcinoma. On September 15, she was sent to the hospital and radium 100 mg. was inserted into the cervix for 36 hours (3600 mg. hrs.). There was no further bleeding until in March, 1935, when the patient reported she had noticed slight spotting. She was readmitted to the hospital and given an additional 2400 mg. hrs. of radium in the cervical canal. On August 28, the cervix looked normal but there had been slight spotting again. She was next seen on September 28, when she reported spotting, and was again admitted to the hospital September 30, 1935.

The abdominal examination revealed no areas of tenderness or muscular rigidity; no masses or organs were palpable. The external genitalia were normal. Vaginal mucosa was atrophic; cervix small, hard and no nodules were palpable. There was a small grayish patch, .5 cm. in diameter, on posterior lip. The uterus was in anterior position and appeared regular in contour and normal in size. The adnexa appeared normal and no masses could be palpated.

There was no albumin or sugar in the urine, which was straw-colored, acid, 1014. A few pus and epithelial cells were found. The red blood count was 4,650,000, hemoglobin 85%, white blood count 4,200, polymorphonuclears 78%, small mononuclears 10%, large mononuclears 7%, eosinophils 5%, Kahn negative.

A panhysterectomy was done on October 1, 1935. The uterus was normal in size. Cut surface showed a polypoid condition of the endometrium. No nodules could be felt in the cervix and when it was cut it seemed to consist mainly of scar tissue. The left ovary was round, hard, and enlarged to the size of a small egg. Cut surface showed some scirrhous growth that had replaced all ovarian tissue. The right ovary was normal.

A section of the cervix was composed of dense fibrous tissue with a normal epithelial lining on the vaginal surface. There was no evidence of malignancy. A section of the ovary was composed almost entirely of fibrous tissue with spots of sclerotic tissue on one side. No malignancy was present. A section of the uterus showed the mucosa to be markedly overgrown and hy-



perplastic, forming a polypoid mass. The glands were invading the wall of the uterus. These glands were irregular in shape and size with a piling up of the cells within the lumen and in places had broken through the basement membrane. A moderate number of mitotic figures were noted. In places the cells of the uterine glands were piled up forming sheets.

A pathological diagnosis was made of adenocarcinoma of the uterus and fibroma of the left ovary.

This patient presented a hyperplasia of the endometrium, an adenocarcinoma of the endocervix, an adenocarcinoma of the body of the uterus and a fibroma of the left ovary. Any one of these pathological conditions could have produced postmenopausal bleeding in her case. The occurrence of an endometrial hyperplasia and later of an adenocarcinoma of the corpus may indicate some relationship between these two conditions. She was last examined Oct. 1, 1937, and has remained perfectly well.

#### DIAGNOSIS

A careful history, complete physical examination and bimanual pelvic examination, with visualization of the cervix, will establish the diagnosis in the majority of these cases, excluding functional type of bleeding and carcinoma of the body of the uterus. Other tests, such as the sedimentation rate, Aschheim-Zondek test, and basal metabolic rate, may be necessary in the differential diagnosis. A uterogram after injection with lipiodol may reveal a filling defect in the uterus due to an intramural or submucous myoma. The most important part of the examination is a diagnostic curettage. This should be done even though some other pelvic pathology is found, for it must be remembered that carcinoma can be associated with other pelvic pathology, particularly myoma. It is only by a diagnostic curettage that hyperplasia of the endometrium and adenocarcinoma of the corpus can be differentiated. Bleeding should never be considered functional until fundal carcinoma has been eliminated. I believe that for a diagnostic curettage the patient should always be given a general anesthetic for only in this way can it be thoroughly done and the interior of the uterus entirely covered. All scrapings should be saved and examined by a competent pathologist.

#### TREATMENT

Radium is a specific in the functional bleeding of the middle-aged group. It will cure 100% of these cases and no other treatment need be considered. The use of the anterior pituitary-like hormone and progestin is not recommended for their use is uncertain. They should be reserved for the younger age group

where the conservation of the ovarian function is desirable. Congo red, snake venom, parathyroid, and thyroid extract should also be reserved for that age group.

At the time of the diagnostic curettage, it is my practice to insert 50 mg. of radium into the uterus for 24 or 36 hours. Usually 1200 mg. hours is a sufficient dosage and more than this may cause undesirable menopausal symptoms. Keene and Payne recommend using even a smaller dosage and repeating it if necessary in the hope of avoiding distressing symptoms of the menopause. Radium in this dosage will also produce a cure in small myomata. The contraindications for radium are the same here as at any other time. The presence of pelvic inflammatory disease and severe anemia are the principal contraindications. Severely anemic patients should be given transfusions before radium is used.

Hysterectomy is not necessary in hyperplasia of the endometrium in the menopausal group and its use should be reserved for the postmenopausal group where a granulosa cell tumor is suspected. Many uteri are removed and the patient needlessly subjected to the danger of a hysterectomy when radium is the treatment of choice.

Carcinoma of the cervix is best treated by radium. Healy and Frazell report a five-year salvage of 27.7% in 551 cases of cervical carcinoma treated with radium. Carcinoma of the body of the uterus should be treated first with an intra-uterine application of radium and a panhysterectomy at the end of six weeks. If the condition of the patient does not permit a panhysterectomy, one should be content with the use of radium alone. Norris and Dunne in reporting 211 cases of carcinoma of the body of the uterus report a five-year salvage of 47.8% with hysterectomy and 43.8% with the use of radium alone.

Ovarian tumors should always be removed surgically in the menopausal or postmenopausal age for over 50% of these tumors are malignant.

#### CONCLUSIONS

1. Malignancy should always be considered first in the abnormal bleeding of middle-aged women. It is the most frequent cause of postmenopausal bleeding and must be considered the cause until it has been disproved.



2. A diagnostic curettage should always be done to differentiate hyperplasia of the endometrium from adenocarcinoma of the corpus of the uterus. Carcinoma may be associated with other pelvic pathology and a curettement should be done before radium or x-ray treatment is given.

3. Prolonged persistent postmenopausal bleeding practically always means carcinoma of the body of the uterus.

4. Radium is a specific treatment for functional bleeding in this group of women and other treatments are unnecessary. There may be some relationship between hyperplasia of the endometrium and carcinoma of the body of the uterus, and the use of radium for hyperplasia may prevent the occurrence of the latter.

5. Radium is the best treatment for carcinoma of the cervix. Radium and a pan-hysterectomy six weeks later, if the patient's condition permits, is the treatment of choice for carcinoma of the corpus.

6. Hyperplasia of the endometrium in the postmenopausal group is usually due to granulosa cell tumor and hysterectomy is indicated even though the tumor cannot be palpated.

7. Ovarian tumor in the middle-aged group should always be removed surgically. The incidence of malignancy is too great to permit expectant treatment.

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long contact and association with not only the indigent sick, but with sick persons who are not indigent, places him in a better position to evaluate the needs of people than anyone more remote. The further fact that the doctor has been accustomed to render service gratis where needed should remove from him the reproach of being motivated by self interest. The traditions of his profession have acted as a sort of *noblesse oblige*.

The survey, the fact-finding part of it, is being left to the county medical society. This is about the only thing that can be done inasmuch as conditions vary with varying localities throughout the United States. Those chosen by county societies to aid in gathering facts will no doubt take the matter seriously, give it plenty of time, and approach the whole subject in a spirit of detachment, so that reliable data may be obtained. Various groups in the community are to be approached and given an opportunity to answer questions in their own language. The correlation of replies and the drawing of conclusions from factual data will be the function of the American Medical Association. The effect of this survey should be to let us know whether we are wrong or right in our impression in regard to the adequacy of medical care; for impressions they are, because no man can get beyond his immediate environment whether he is a general practitioner in the ranks, or a professor of medicine.

### NEW AND NONOFFICIAL REMEDIES, 1938

In this book the Council on Pharmacy and Chemistry lists and describes the medicinal preparations that it has found acceptable for general use by the medical profession. A glance at the list of the Council members and the long list of consultants appearing in the first part of the book gives ample warrant for the authority of the Council's selections.

New substances described in this volume are Sulfanilamide and Protamine Zinc Insulin, with the accepted brands. The proved value of these new additions to the physician's armamentarium bids fair to make the past year a milestone in therapeutic progress. The Council is to be congratulated on the promptness with which it evaluated these

## AMERICAN MEDICAL ASSOCIATION SURVEY

Perhaps the majority of physicians are under the impression that medical care, for those who require it, is being adequately provided. A minority of physicians, among them those who are holding salaried positions, appear to think otherwise, and have so expressed themselves. The object of the survey conducted by the American Medical Association is to ascertain the truth of the matter. Is medical care adequate in the United States?

The agitation for change in the *modus* of medical practice has come for the most part from socially minded writers who have used up much space in lay magazines during the past few years. Little or no demand for change appears to have come from the people at large. Many, when questioned in regard to alleged state or socialized medicine, do not know what the questioner means.

Surveys are apt to be tinctured by bias or self interest. The social worker who has come into being of recent years is interested in making a place for himself in the scheme of things. It must not be denied, however, on the other hand that the doctor is also an interested person. We believe, however, that the doctor's



drugs and established standards for their adequate control. From the first the Council warned against using Sulfanilamide in untried combinations. The sad tragedy of the deaths from the rashly introduced Elixir of Sulfanilamide-Massengill starkly emphasizes the value of such a body as the Council to the medical profession and the pharmaceutical manufacturers as well as to the public. Of course this potential value cannot become effective as long as those concerned refuse to follow the Council in the use of new remedies.

Other noteworthy new drugs which appear in New and Nonofficial Remedies, 1938, are Avertin with Amylene Hydrate, Vinethene, Pontocaine Hydrochloride, basal, general and local anesthetics respectively; Novatropine and Syntropan, synthetic mydriatics.

Physicians who wish to know why a given proprietary is not described in New and Nonofficial Remedies will find the "Bibliographical Index to Proprietary and Unofficial Articles Not Included in N. N. R." of much value. In this section (in the back of the book) are given references to published articles dealing with preparations that have not been accepted. These include references to the Reports of the Council, to Reports of the A.M.A. Chemical Laboratory and to articles that have appeared in The Journal of the American Medical Association.

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#### ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY

This book, published by the American Medical Association, is a great deal more than a mere record of the negative actions of the Council on Pharmacy and Chemistry. It gives in full the reasons for the Council's rejection of various preparations, but it also records results of the Council's investigations of new medicinal agents not yet out of the experimental stage, and frequently contains reports on general questions concerned with the advance of rational drug therapy. All three categories of reports are represented in the present volume.

This issue of the Reports is remarkable for the series of valuable status and preliminary reports published by the Council in the past year. These include the reports on Avertin

with Amylene Hydrate (now accepted for New and Nonofficial Remedies), Benzedrine Sulfate (the active constituent of the notorious "pep" pills but a promising drug when its limitations are recognized), Catgut Sutures (a survey of the sterility of the market supply), Evipal Soluble (a comprehensive review of the evidence for the usefulness and limitations of the drug), Histidine Hydrochloride (a study of the usefulness of the drug in peptic ulcer, to be considered in connection with the report rejecting Larostidin, a proprietary brand, for unwarranted and exaggerated claims), Mandelic Acid (an authoritative statement of the limitations of this drug which the Council has now accepted), and Vinethene (a careful study of the evidence for the drug, which the Council has accepted for one year as an anesthetic to be used in short procedures).

Other notable reports of outright rejection of products are those on Causalin (Causyth), an unsafe and dangerous preparation proposed for use in arthritis; Glutamic Acid Hydrochloride-Calco, proposed as a conveyor of hydrochloric acid, with unsubstantiated claims of clinical effectiveness; Larodon "Roche," proposed as a substitute for other well established analgesic and antipyretic drugs and marketed with exaggerated and unwarranted claims.

Two reports on Sulfanilamide appear, a nomenclature and status report together with reprints of J. A. M. A. editorials giving the warnings which, if obeyed, would have avoided the series of deaths which resulted from the marketing of the ill-fated Elixir of Sulfanilamide-Massengill.

At the end of this volume appears an eulogy of George Henry Simmons whose death deprived the Council on Pharmacy and Chemistry of its founder and American medicine of a worthy and faithful servant.

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#### MEDICAL DISTRICT MEETINGS

Ponte Vedra (C) . . . . . September 15, 1938  
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Ft. Lauderdale (F) . . . . . October 13, 1938  
Gainesville (B) . . . . . October 27, 1938  
Eustis (E) . . . . . November 10, 1938

## BROADCASTS OVER WRUF

The cooperation of the University of Florida, Gainesville, through its broadcasting department during the past year, has been very much appreciated. This means of reaching the general public has undoubtedly given many citizens reliable information concerning certain preventable diseases and how to proceed when sick or in need of the services of a surgeon. Education is the greatest protection and the effort of the officials of our own State University in encouraging the broadcasting of authentic health information over WRUF is very commendable.

Since most of the calls for copies of broadcasts are received from the laity, the Association's Committee on Public Relations has decided to publish a short synopsis of what was covered in each radio address and not reproduce the complete text of each broadcast. Anyone desiring a complete copy of an individual broadcast is requested to write the Florida Medical Association, Box 1018, Jacksonville.

## RADIO BROADCASTS

## THE SCHOOL CHILD AND TUBERCULOSIS—

Logie, Arthur Jones, Jacksonville.

The anti-tuberculosis program of the State Board of Health is explained. Tuberculin test described and importance of x-ray stressed. Recommendation that all school children be tested upon entrance to high school and college.

## IMMUNIZING THE PRE-SCHOOL CHILD—von Meysenbug, Ludo, Daytona Beach.

A history of the development of immune serums for smallpox, diphtheria, whooping cough, typhoid fever, measles, and scarlet fever. Relative efficiency of these preventatives given. Cost of immunization and of illness compared.

## THE IMPORTANCE OF DIAGNOSIS — Bowie, Clyde F., Leesburg.

Some modern diagnostic aids mentioned. The danger of self-diagnosis in cases of headache, pain in abdomen, and blood in urine. High maternal mortality rate in Florida, giving cause. Importance of early diagnosis stressed.

## ALLERGY IN CHILDHOOD—Sinclair, William Ewing, Orlando.

Interpretation of term "allergy," giving examples of foods, inhalants, and skin irritants. Symptoms. Scratch and intracutaneous tests explained. Treatment by: removal of offending substance; injections to overcome sensitivity. Progress made in this field in last twenty years.

## OUR RESPONSIBILITY TO OUR MENTALLY ILL AND STATE HOSPITAL—Robertson, J. C., Chattahoochee.

A discourse on the increase in patient population in the Florida State Hospital over a period of eight years, resulting in present overcrowded condition. Cost to taxpayers of caring for inmates. An appeal to citizens to help bring about more modern treatment for these unfortunates.

## HOW TO CHOOSE ONE'S FAMILY PHYSICIAN—Turberville, J. K., Century.

Importance of choosing family physician before illness occurs. Two important factors enter into choice: medical training, and character of physician. By careful selection, incompetent and unscrupulous would be forced out of practice.

## THE NEED FOR A BETTER SPIRIT OF CO-OPERATION AMONG COUNTY OFFICIALS, SCHOOL TEACHERS, AND RURAL DOCTORS IN SOLVING THE MENTAL, PHYSICAL AND SOCIOLOGICAL PROBLEMS OF RURAL POPULATIONS—Anderson, James M., Cross City.

In Florida's rural schools five out of six children underprivileged. Recommends nursery schools for check-up of hookworm, malaria, and other diseases. Describes first county nursery school established in 1933 where 100% were hookworm infested; 55% had malaria. Shows monetary returns on investment by county sponsoring such plan.

## RELATION BETWEEN PHYSICIAN AND THE FAMILY—Dell, J. M., Jr., Gainesville.

Certain conventions which should be observed by the patient's family in calling a doctor, during and after the examination. The necessity for such conventions and their importance in facilitating the handling of the case.

BLADDER TROUBLE—Mills, Alvin M., St. Petersburg.

Symptoms which are apparent to laymen. Some causes enumerated of inflammation of bladder and urinary passage, pus, bloody urine, stones, incontinence. Difficulty of differential diagnosis makes thorough examination essential.

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APPENDICITIS—Boling, John R., Tampa.

Description of appendix. Usual symptoms of appendicitis. Explanation of what occurs in appendix during attack. Necessity for early diagnosis and immediate operation. Dangers of self-treatment in case of abdominal pain, particularly by use of laxatives.

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BE A WELL-BALANCED INDIVIDUAL: BE MENTALLY AND PHYSICALLY FIT—Spengler, N. L., Tampa.

Body building. Importance of physical culture, properly administered. Harm done to various organs by excessive eating. Diseases from overweight; effect on mental condition. Importance of good mental and physical habits established in childhood.

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VITAMINS—von Meysenbug, Ludo, Daytona Beach.

The mad rush for vitamins. Vitamins in natural foodstuffs. Enumeration and explanation of Vitamins A, B<sub>1</sub>, B<sub>2</sub>, C, D, with diseases resulting from deficiency. Mention of Vitamin E.

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ARTHRITIS—Vallotton, J. Ralph, Daytona Beach.

Prehistoric existence of arthritis. Statistics showing its economic and social importance. Infection as a cause. Discussion of heat, diet, vaccines and drugs in treatment.

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A FEW KNOWN FACTS ABOUT CANCER—Wells, J. Ralston, Daytona Beach.

Early symptoms of Cancer. Cancer not contagious or hereditary. Only surgery, x-ray and radium reliable in treatment. Cancer statistics. Work of Women's Field Army in spreading knowledge concerning this disease.

RHEUMATISM OR CHRONIC ARTHRITIS—Ash-ton, W. L., Umatilla.

Rheumatism most common cause of prolonged disability. The need for institutions specializing in treatment of arthritis. Treatment: diet, heat, vaccines, massage. Medical profession can successfully help the rheumatic person in every stage of disease.

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X-RAYS IN DISEASE—Wood, Will L., Eustis.

X-ray diagnosis, enumerating some conditions and diseases in which properly used. Manner in which x-ray and fluoroscope operate. X-ray therapy; its place in treatment of cancer. Danger of x-ray in unskilled hands.

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HOW TO GET THE MOST FROM YOUR DOCTOR—Ames, A. M., Pensacola.

The patient's proper approach in consulting doctor. Importance of confidence in and cooperation with attending physician. The family physician. Consultations. Necessity of giving physician free hand in management of illness.

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THE MEDICAL PROFESSION: ITS VALUE TO SOCIETY—Lischkoff, M. A., Pensacola.

The service of the physician to mankind in preventing illness and in curing disease. Work of Pasteur, Koch, Long, and Roentgen mentioned. Statistics given to show decline in death rate from preventable diseases. Advocates that each person budget 10% of income for medical service inasmuch as economic safety is built on health.

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PRENATAL CARE—Carter, Claude L., Inverness.

Statistics on maternal mortality, showing percentage of preventable deaths. Importance of early examination of pregnant woman. Discussion of diet, exercise and clothing during pregnancy.



SECTIONAL MEETING, SURGICAL  
CONGRESS

Mr. J. H. Therrell, Superintendent of the Florida State Hospital at Chattahoochee, has invited the Florida Section of the Southeastern Surgical Congress to hold its next clinical session at the State Hospital at Chattahoochee, Saturday, August 27.

At a recent conference between Mr. Therrell and Doctor Stevens of the State Hospital, and the Clinic Committee of the Florida Section of the Congress, arrangements were completed for what promises to be a most successful meeting.

Since the hospital is located within a mile of the Georgia State line, and only about forty miles from the Alabama State line, invitations will be extended to the members of the State Medical Associations of both Georgia and Alabama to be present at this meeting.

At the State Hospital there is a wealth of clinical material available for demonstration and discussion. There will be no set papers, but clinical cases will be presented and discussed by invited guests.

The list of speakers who have already accepted invitations to be present comprise the following:

Dr. James S. McLester, Sr., Birmingham, Alabama,  
Past President American Medical Association.  
Dr. T. C. Davison, Atlanta, Georgia,  
President Southeastern Surgical Congress.  
Dr. Walter C. Jones, Miami, Florida  
Dr. Walter Holmes, Atlanta, Georgia  
Dr. J. G. Lyerly, Jacksonville, Florida  
Dr. W. McL. Shaw, Jacksonville, Florida  
Dr. Fred Wilkerson, Montgomery, Alabama  
Dr. William R. Meeker, Mobile, Alabama

The hospital authorities will entertain the audience at lunch and the meeting will be so timed that physicians living within a radius of seventy-five or one hundred miles can be present during the entire meeting and still return home before dark.

The Florida Committee consists of:

Dr. J. S. Turberville, Century, Chairman  
Dr. J. C. Davis, Quincy  
Dr. F. D. Gray, Orlando  
Dr. W. C. Jones, Miami  
Dr. Ed. Jelks, Jacksonville

## STATE NEWS ITEMS

## SEBRING GENERAL HOSPITAL

On Sunday, April 24, the Sebring Hospital was formally opened. This beautiful building at the corner of the Circle and West Center Drive, built during the boom, was recently purchased by Dr. L. W. Martin.

The building has been entirely remodeled and redecorated. It has been equipped with the latest appliances and furnished with an eye to beauty as well as comfort. The building can be easily identified by the words, "General Hospital," done in large letters of gold, over the entrance way which leads directly into the attractive foyer. This beautiful hospital building is three stories in height and every floor has been finished artistically. The citizens of Sebring, as well as the local press, have complimented Doctor Martin for his visionary incentive which prompted him to conceive the idea. They feel that hospital facilities in Sebring are now on a par with those of much larger cities and offer to visitors within their gates adequate hospital accommodations.

\* \* \*

## FLORIDA EAST COAST MEDICAL MEETING

The Florida East Coast Medical Association will hold its annual meeting in late October or early November at Rockledge.

This location being so near the center of the Association's geographical and population area should insure one of the largest meetings ever held. As usual, an excellent program will be offered.

Those desiring space on the program should send abstracts of papers with names of discussors to the Chairman of the Program Committee, Dr. E. C. Swift, 615 Greenleaf Building, Jacksonville. This committee will meet not later than August 15.

\* \* \*

Dr. Charles B. Mabry of Jacksonville has returned from Chicago, where he attended clinics.

\* \* \*

Dr. and Mrs. Louie Limbaugh and Dr. and Mrs. E. W. Veal of Jacksonville, after attending the A. M. A. convention in San Francisco, visited Vancouver, Lake Louise and Banff, and Montreal, Canada.

District "E" is the first medical district to have a 100% paid-up membership. Drs. H. D. Clark of Ft. Pierce and Walter C. Page of Cocoa are the councilors in this district, which comprises the counties of Brevard, Indian River, Lake, Martin, Okeechobee, Orange, Osceola, St. Lucie, and Seminole.

\* \* \*

Dr. Lucien Y. Dyrenforth of Jacksonville was speaker at a regular luncheon meeting of the Professions Club of that city on June 28. His subject was "Pressure Impregnation of Timber." Doctor Dyrenforth, a member of the club, is a registered professional engineer as well as a doctor of medicine.

\* \* \*

Dr. and Mrs. Robert B. McIver of Jacksonville spent some time during June in New York City. Before returning home they attended the meeting of the American Urological Association at Chateau Frontenac in Quebec.

\* \* \*

Dr. C. J. Bible of Miami announces the removal of his office to 1243 N. W. First Street.

\* \* \*

Drs. R. R. and Caroline Hilborn of Bunnell announce their removal to Stanfield, N. C.

\* \* \*

Dr. and Mrs. F. S. Whitman of West Palm Beach have gone to Linville, N. C., where Doctor Whitman is house physician at Escala Lodge. In October Doctor Whitman will go to New York where he will take a post-graduate course.

\* \* \*

Dr. and Mrs. J. Maxey Dell, Jr., of Gainesville returned on May 31 from a month's stay in Washington, D. C., where Doctor Dell did special work.

\* \* \*

Dr. James B. Parramore of Key West, Director of the Monroe County Health Department, and Miss Juliette Cruz were married in Ft. Lauderdale on February 21.

\* \* \*

Dr. and Mrs. J. Maxey Dell of Gainesville announce the marriage of their daughter, Mary Virginia, to O. N. Harper, Jr., on June 1, 1938.

President W. Henry Spiers has just announced that the delegates from this Association to the meeting of the Medical Association of Georgia for 1939 will be Drs. Gerry R. Holden, Jacksonville; Homer L. Pearson, Jr., Miami; and Walter C. Page, Cocoa.

\* \* \*

Dr. C. J. Collins of Orlando was certified by the American Board of Obstetrics and Gynecology at the meeting of the American Medical Association in San Francisco during its last annual meeting.

\* \* \*

The Southeastern Dermatological Association which was organized in Jacksonville in 1934, will hold its fourth annual meeting at Charlotte, N. C., September 4. Dr. J. L. Kirby-Smith of Jacksonville is Chairman and Dr. Joseph Elliott of Charlotte is Secretary. This dermatological society includes in its membership all the dermatologists in the southeastern states. The last meeting was held in Birmingham, Ala.

\* \* \*

Dr. H. Marshall Taylor of Jacksonville, a former president of the Florida Medical Association, was signally honored at the last meeting of the American Medical Association, when he was named chairman of the Association's section on Laryngology, Otology, and Rhinology.

\* \* \*

Dr. William D. Lithgow and family of Miami are spending July and August on a Mediterranean cruise, visiting Rome, Athens, Istanbul, Jerusalem, Cairo, etc.

\* \* \*

Dr. Lauren Sompayrac of Jacksonville is taking a three-months' postgraduate course in dermatology at the New York Postgraduate Medical School, under Doctor MacKee and associates.

\* \* \*

Dr. R. C. Dennison of Lake Worth died June 15 at the Good Samaritan Hospital, West Palm Beach, after an illness of several months.

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JEFFERSON DAVIS FORSTER

Jefferson Davis Forster was born in Fayette, Missouri, October 24, 1870, the ninth child of the Reverend and Mrs. Francis Xavier Forster. As a young man he turned to the study of medicine and in 1896 was graduated from Barnes College, St. Louis. He later returned to hold a professorship at his Alma Mater.

Doctor Forster spent a great deal of time in postgraduate study over a period of years following his graduation. In 1902 he took special work and acted as Assistant in Gynecology in the New York Hospital. In 1903, he did work in gynecology, obstetrics and operative technic at Johns Hopkins University. In 1905 he secured leave of absence from Barnes University for special study in Europe where he worked in clinics, hospitals and universities in Dublin, Glasgow, Edinburgh, Leeds, London, Paris, Berne, Berlin, Dresden, Prague and Vienna.

In 1907, he organized the St. Louis Maternity Hospital and served as Chief of Staff until 1910 when, because of sickness, he was compelled to leave, and came to Sanford, Florida, where he operated a celery farm for one year. Coming to Hawkes Park, now Edgewater, Doctor Forster organized the Forster Sanitarium, where he remained until 1923, when he opened private practice in New Smyrna Beach.

Doctor Forster was prominent in medical and civic circles. He served as president and also as secretary of the Volusia County Medical Society, as councilor of the seventh district of the Florida Medical Association, secretary of the Obstetrics Section of the St. Louis Society, member of Directors of the Florida Development Board for two years, National Executive Committeeman representing Florida for four years, member of the National Rehabilitation Committee of the American Legion for two years, and as president of the New Smyrna Chamber of Commerce for three years.

The following resolution on the death of Doctor Forster was recently passed by the Volusia County Medical Society:

## RESOLUTION

WHEREAS one of our beloved members, DR. JEFFERSON DAVIS FORSTER, has been called beyond, bringing sorrow to the members of

the Volusia County Medical Society, and to the members of his family, and friends throughout the community.

WHEREAS, the recent death of DR. JEFFERSON DAVIS FORSTER has taken from the Volusia County Medical Society one of its oldest and most valued members, whose adherence to the ethical standard of Medicine and loyalty to his profession—whose professional attainments made him an important member of our Society,

THEREFORE, the members of The Volusia County Medical Society, in regular session officially go on record as being deeply grieved at the loss of our member, and we extend our heartfelt sympathy to those who are near and dear to him.

THEREFORE *Be It Resolved* that as an evidence of profound regret for our loss and sympathy for his family it is hereby directed that this resolution be spread upon the minutes of the Volusia County Medical Society; a copy forwarded to his family; and the secretary be directed to notify the Florida Medical Journal of his death.

THE VOLUSIA COUNTY MEDICAL SOCIETY,  
L. B. BOUCHELLE,  
H. W. HENRY.

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## THOMAS WALTER WITT

Dr. Thomas Walter Witt of Lake City died on June 8, following an illness which forced his retirement from practice in 1933.

Doctor Witt was born in Columbia County in July, 1891, and received his preliminary education there. He graduated from the medical department of Emory University in 1915. He was married the same year to Miss Lilla Dawkins of Jefferson County, to which union a son, Gerald, was born.

Following his graduation, Doctor Witt practiced medicine for a number of years in Columbia City, Florida. In 1922 he moved to Lake City where he continued his practice until ill health forced his retirement in 1933.

Doctor Witt was a member of the Columbia County Society until he retired from practice, serving one year as secretary; a member of the Methodist Church, the Elks, and the Morocco Temple of the Shrine. He served one term on the City Commission, and also was a past president of the Lake City Kiwanis Club.

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## COMPONENT COUNTY SOCIETIES

## DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society held its regular meeting on the evening of July 5 at the Ingraham Building. The following papers constituted the scientific program:

"Hypoglycemic Shock Therapy" (illustrated by films)—James L. Anderson, Miami.

"Diagnosis of Pregnancy: Review of Laboratory and Clinical Procedures"—Ralph Jack, Miami.

Drs. E. F. Fox and Buist Litterer opened the discussion.

\* \* \*

## LAKE COUNTY MEDICAL SOCIETY

The regular meeting of the Lake County Medical Society was held June 1 at the Theresa Holland Hospital at Leesburg, the members being guests of Dr. H. G. Holland. Dr. Clyde F. Bowie of the staff of Holland Hospital, read a paper on "Kidney Infections and Calculi."

The Lake County Society recently acquired by gift, the Fountain Inn at Eustis, with the stipulation that the building be used as a hospital. Remodeling is in progress and the new hospital will be ready for occupancy on July 15. The equipment now in use at the hospital at Umatilla will be moved to the new quarters at Eustis.

\* \* \*

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON  
COUNTY MEDICAL SOCIETY

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held at Chattahoochee, Thursday, April 21, at 3 p. m. The following papers constituted the scientific program:

"The Gall Bladder"—Ernest B. Milam, Jacksonville.

"The Influence of Malarial Infection on Wassermann and Kahn Reaction"—S. F. Kitchen, Tallahassee.

"Management of the Diabetic Patient"—G. H. Garmany, Havana.

\* \* \*

## ORANGE COUNTY MEDICAL SOCIETY

At a recent meeting of the Orange County Medical Society, the following resolution was passed with reference to the death of Dr. P. M. Lewis:

## RESOLUTION

After fifteen years of active practice and six years of lingering illness, on April 30, 1938, Doctor P. M. Lewis passed from this life into the unknown beyond, from which bourne no traveler ever returns. Now,

Whereas, we as medical practitioners, feel his loss as a friend, counselor, and a brother practitioner, therefore be it

Resolved, that we, the members of the Orange County Medical Society, express our grief and profound sympathy to his bereaved family, and furthermore, be it

Resolved, that a copy of this resolution be spread on the minutes of our society, a copy sent to Mrs. Lewis, and a copy sent to the Florida Medical Journal for publication.

## Resolutions Committee

C. J. COLLINS, *Chairman*

W. H. SPIERS

HEWITT JOHNSTON

\* \* \*

PASCO-HERNANDO-CITRUS COUNTY  
MEDICAL SOCIETY

The Pasco-Hernando-Citrus County Medical Society, at its regular meeting Thursday evening, May 26, was entertained by Dr. W. Wardlaw Jones at Dade City. Dinner was served at the Edwinola Hotel, followed by the scientific session. An interesting case report was given by Dr. J. T. Bradshaw and Dr. W. W. Jones.

Reports were made by Drs. S. C. Harvard and W. W. Jones, delegates to the annual meeting in Miami, and by Dr. W. H. Walters. On motion, it was decided that the society would not hold meetings in June and July. Members present were Drs. J. T. Bradshaw, G. R. Creekmore, H. L. Harrell, S. C. Harvard, W. W. Jones and W. H. Walters.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held its semi-monthly meeting at the Chatterbox on the evening of July 1. Dr. A. J. Bieker of St. Petersburg was principal speaker, delivering a paper on "Cardiology in Aviation."



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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Observations on Early Diagnosis of Gastro-intestinal Cancer—JELKS, EDWARD, Jacksonville, South. Surg. 6:299-304 (Aug.), 1937.**

The diagnosis of carcinoma of the gastro-intestinal tract is still a problem in spite of the increased attention attracted to it by medical and lay emphasis. One of the greatest causes of delay at present is the failure to suspect such a diagnosis in vague gastro-intestinal disturbances, before ill health is evident.

Seven symptoms which should be kept in mind as possibly linked to these early lesions are:

1. Loss of appetite, frequently an early symptom in cancer of the stomach.
2. Fullness after eating, often seen in malignancies in the upper tract.
3. Weakness, due to the lack of nourishment, or to developing anemia.
4. Anemia, usually due to slow leakage, and only recognized by occult blood in stool examinations.
5. Intermittent diarrhea and constipation, due to lesions in the large bowel, and not necessarily a very early symptom.
6. Change in color of the stool which may, if noticed, lead to suspicion of bleeding and its cause.
7. Change in gastro-intestinal life such as the vague intermittent dyspepsias, chronic indigestions and so-called "bilious spells."

To adequately study the gastro-intestinal tract to rule out malignancy one must always be ready to suspect cancer and a stool examination for occult blood is most important. Next in importance is the digital rectal examination to be followed by the sigmoidoscopic examination. Then a thorough roentgen study of the whole tract is necessary, unless obstruction is evident. In suspected carcinoma of the stomach gastroscopic studies are indicated unless hemorrhage and cardiac stricture prevent.



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**Inexpensive "Traction Irons" for Well Leg Counter Traction—DOZIER, HENRY C., Ocala, South Surg. 6:293-298 (Aug.), 1937.**

Dozier describes a device of his own invention which is utilized for "well leg counter traction" without the use of "bone pins."

These "traction irons" seem to have many advantages over previous methods. They can be made up in any machine shop at an approximate price of \$3.50. They are applied with little pain and hence do not as a rule require any anesthesia, nor is there subsequent pain after application. No particular surgical skill is required. There is no danger of infection or osteoporosis as is the case when "pins" are used.

The irons are incorporated directly into the plaster cast and traction is secured by two longitudinal bolts which screw into two transverse bars at different levels on the two legs.

For detailed information as to their construction, the reader is referred to the original article in which adequate diagrams and illustrations may be found.

**Visualization of Shatter-Proof Glass in the Tissues—DELL, J. MAXEY, JR., Gainesville, Am. J. Roentgenol. 38:781-782 (Nov.), 1937.**

Attention is called to the presence of shatter-proof glass in wounds after automobile accidents. They may be overlooked if buried deeply and become a later source of irritation which because of the characteristics on x-ray may lead to a diagnosis of bone in the tissues. Two cases are reported.

**Restoration of St. Augustine, Florida—A Survey of Medical History—SPENCER, J. J., St. Augustine, Ann. Med. History, New Series, Vol. 9 (Sept. 13), 1937.**

Spencer discusses the proposed historical survey and restoration of St. Augustine. His interest is particularly concerned with a compilation of its medical history from the time of the landing of Menendez through the early period following the United States purchase.

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### REFERENCES

1. "Treatment of Human Pellagra with Nicotinic Acid"—Fouts, Helmer, Lepkovsky and Jukes: *Proc. Soc. Exp. Biol. and Med.*; 37: 405; (Nov.) 1937.
2. "Relation of Nicotinic Acid and Nicotinic Amide to 'Canine Black-tongue'"—Elvehjem, Madden, Strong and Wooley; *Jrl. Amer. Chem. Soc.* 59:1767; (Sept.) 1937.
3. "Therapeutic Administration of Nicotinic Acid in Human Beings During Health and Disease"—Spies, Cooper and Blankenhorn. (Read before the Central Society for Clinical Research, Chicago—Nov. 1937).
4. "Nicotinic Acid and the Pellagra Preventing ('P-P') Vitamin"—Harris; *Chem. & Ind.*; 56:1134; (Dec.) 1937.
5. "Pellagra Successfully Treated with Nicotinic Acid—A Case Report"—Smith, D. T., M.D.; *Jrl. A.M.A.* 109:2054; (Dec. 18) 1937.
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8. "Relation of Nicotinic Acid to Human Pellagra." An editorial—*Jrl. A. M. A.* 109:1203; 1937 (Oct. 9).
9. "The Use of Nicotinic Acid in the Treatment of Pellagra"—Spies, Cooper and Blankenhorn; *Jrl. A. M. A.* 110:622; 1938 (Feb. 26).
10. "Advances in the Treatment of Pellagra." An editorial, *Annals of Internal Medicine*, 11:1760; 1938 (March).
11. "A note on the Relationship of Porphyrinuria to Human Pellagra." by Tom Douglas Spies, M. D.; Yasuo Sasaki, Ph. D.; and Eather Gross, M. S., *Southern Medical Journal*, Vol. 31, No. 5, May, 1938, page 483.

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## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**THE ROMANCE OF PROCTOLOGY.** By CHARLES ELTON BLANCHARD, M. D., Alumnus Western Reserve Medical School, Class of 1902, C. C. P., & S.,—teacher, writer, lecturer. A story of the history and development of this branch of surgery from its earliest times to the present day, including brief biographic sketches of those who were its pioneers. Cloth. Price \$4.50. Pp. 284, with illustrations. Youngstown, O., Medical Success Press, 1938.

**PNEUMONIA AND SERUM THERAPY (Revised Edition).** By FREDERICK T. LORD, M. D., Clinical Professor of Medicine, Emeritus, Harvard Medical School; and RODERICK HEFFRON, M. D., Field Director, Pneumonia Study and Service, Mass. Dept. of Public Health. This book was published in 1936 under the title *Lobar Pneumonia and Serum Therapy*. The present edition includes additional data subsequently made available, particularly with regard to dosage, the use of rabbit antiserum, and the results of specific treatment of Types I, II, V, VII, VIII, and XIV pneumonia. Cloth, Price \$1.00. Pp. 148, with illustrations. New York: The Commonwealth Fund, 1938.

**A WOMAN SURGEON: THE LIFE AND WORK OF ROSALIE SLAUGHTER MORTON.** Good autobiographies are greatly appreciated. That of the distinguished woman surgeon, Rosalie Slaughter Morton of Winter Park, Florida, is a gem. It is a deeply moving story of the evolution of one of the most prominent pioneer women surgeons in the United States. The true tale is full of thrilling, touching or amusing stories. Personal reminiscences are interspersed with sketches of various nations; extensive travel and exciting personal adventures are described with a narrative technic rarely found in modern biography. The entertaining book not only provides delightful reading material but offers a picture of an exemplary life, worthy of imitation. Cloth. Price \$3.00. Pp. 399, with one illustration. New York: Frederick A. Stokes Company, 1937.

**A MORAL HISTORY OF WOMAN.** By SARAH PARKER WHITE, M. D., Florida State College for Women, Tallahassee. An account of the advances that woman has made toward economic and sexual freedom, from prehistoric times to the complex civilization of today. Doctor Elwood Worcester has said "Among modern writers, DOCTOR WHITE is the first, or one of the first, to perceive the endless possibilities in the renewal of a worn-out civilization by this new representative of humanity. It is largely for this reason that I have found the study of her book so stimulating." Cloth. Price \$3.00. Pp. 324, with illustrations. Garden City, N. Y.: Doubleday, Doran & Co., Inc., 1937.

**NEW AND NONOFFICIAL REMEDIES, 1938.** Containing descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1938. Cloth. Price, \$1.50. Pp. 592, LXVI. Chicago: American Medical Association, 1938.

**ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY** of the American Medical Association for 1937, with the Comments That Have Appeared in the Journal. Cloth. Price, \$1.00. Pp. 201. Chicago: American Medical Association.



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**SIMPLIFIED ANALGESIA IN UROLOGY**

Joseph E. F. Laibe

(Asso. Clin. Prof. of Urol., Loyola University)

Ill. Med. Jour., 73: 224 (March) 1938.

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For major surgery, Dilaudid, 1/20 grain, and atropine, 1/150 to 1/100 grain are given about forty-five minutes before the operation, which is usually done under ethylene or nitrous oxide. In general, Laibe found Dilaudid a satisfactory opiate for pre- or post-operative use, as well as in such conditions as renal colic, bladder spasm, etc. In concluding his report he states:

"1. Adequate analgesia for cystoscopies is often obtained by using morphine, grain 1/6 to 1/4, or Dilaudid, grain 1/32 to 1/20, with scopolamine, grain 1/150 to 1/100, depending on the weight and irritability of the patient. If such a procedure is used the risk of depression is not as great as when inhalation or spinal anesthesia are used.

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### NEXT SESSIONS

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# BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

## VI. COOLING THE TIN CONTAINER AFTER THERMAL PROCESSING

● On this page we have previously described certain basic operations in commercial canning procedures. These have included cleansing of the raw material; blanching; exhausting or pre-heating; sealing the tin container; and thermal processing of the sealed container. In this—the last of this series—we shall discuss the final basic operation, namely, the cooling of the sealed can immediately after the heat process.

One main reason for rapid and thorough cooling of the can contents—as soon as the objective of the heat treatment has been fulfilled—is more or less self-evident. Prompt cooling checks the action of the heat and thus prevents undue softening in texture or change in color of the food. Also important, particularly in the case of foods of an acid nature, is the prevention of excessive chemical action between the food and the metal container, which may occur if the contents of the can remain hot for an extended period of time. In modern practice, two types of cooling are commonly used, namely, air cooling and water cooling.

Air cooling, as the name implies, involves cooling of the tin container by facilitating radiation of its heat into the air. This type of cooling is adaptable to certain products in small cans. In other products, or in the case of larger cans, it is employed chiefly when the slower loss of heat, characteristic of this cooling method, is essential either for preservation of the food, or for the production of certain quality characteristics in the final product. Modern air cooling is accomplished in well ventilated, specially designed warehouses where the cans are piled in rows, allowing ample space between rows for efficient air circulation.

The several methods of water cooling and the technique by which they are carried out are detailed elsewhere (1). Briefly, water cooling may be effected in a variety of ways. The hot cans may be cooled by admitting water into the retort in which they were processed, or they may be cooled after removal from the retort by conveying the cans through tanks of cold, running water or through cold water showers. Large size, or irregularly shaped cans—processed under steam pressure—must be cooled in the closed retort at the end of the process to avoid undue strain on the containers. This is accomplished by “pressure cooling” in which pressure is maintained in the retort during the cooling of the cans, to counterbalance the pressure which develops during the process within the can itself. Commercially, cans are water-cooled to about 100°F. so that enough residual heat remains to dry the can exterior.

Present day canners are fully aware of the importance of cooling their products rapidly and completely as soon as the process is completed, in order to insure the production of canned foods with high quality characteristics. Consequently, in modern canneries the cooling operations are strictly supervised like the other basic operations in the commercial canning procedure. After inspection and labeling, the cooled cans are then ready to enter distribution channels for delivery to the consumer.

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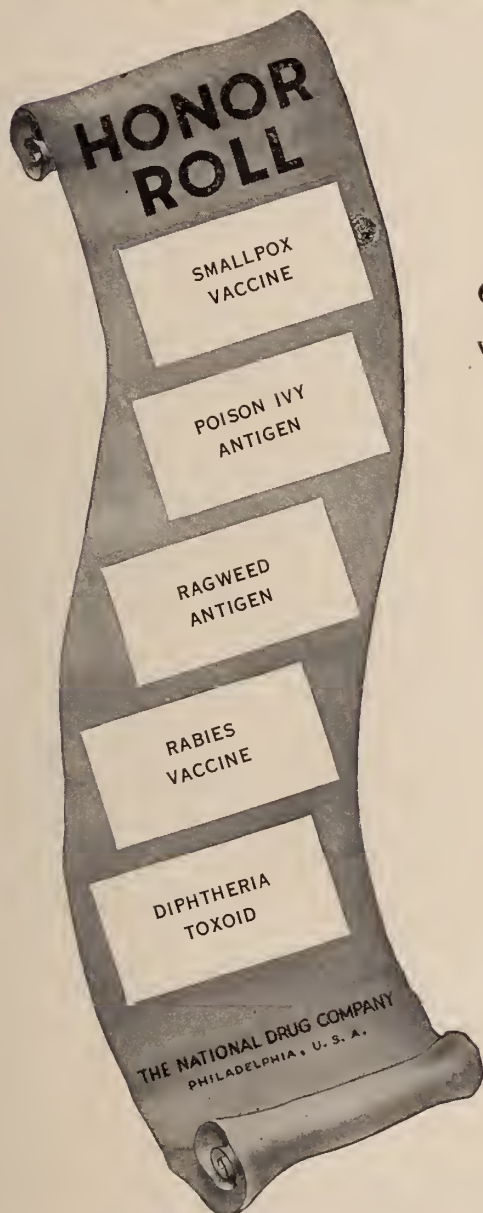
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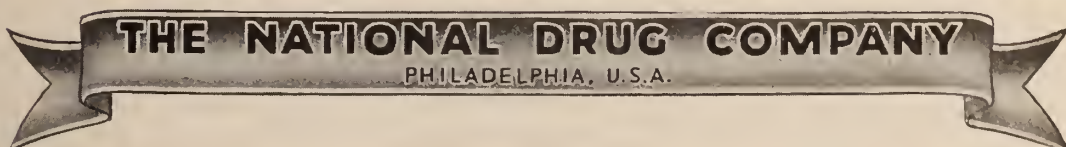
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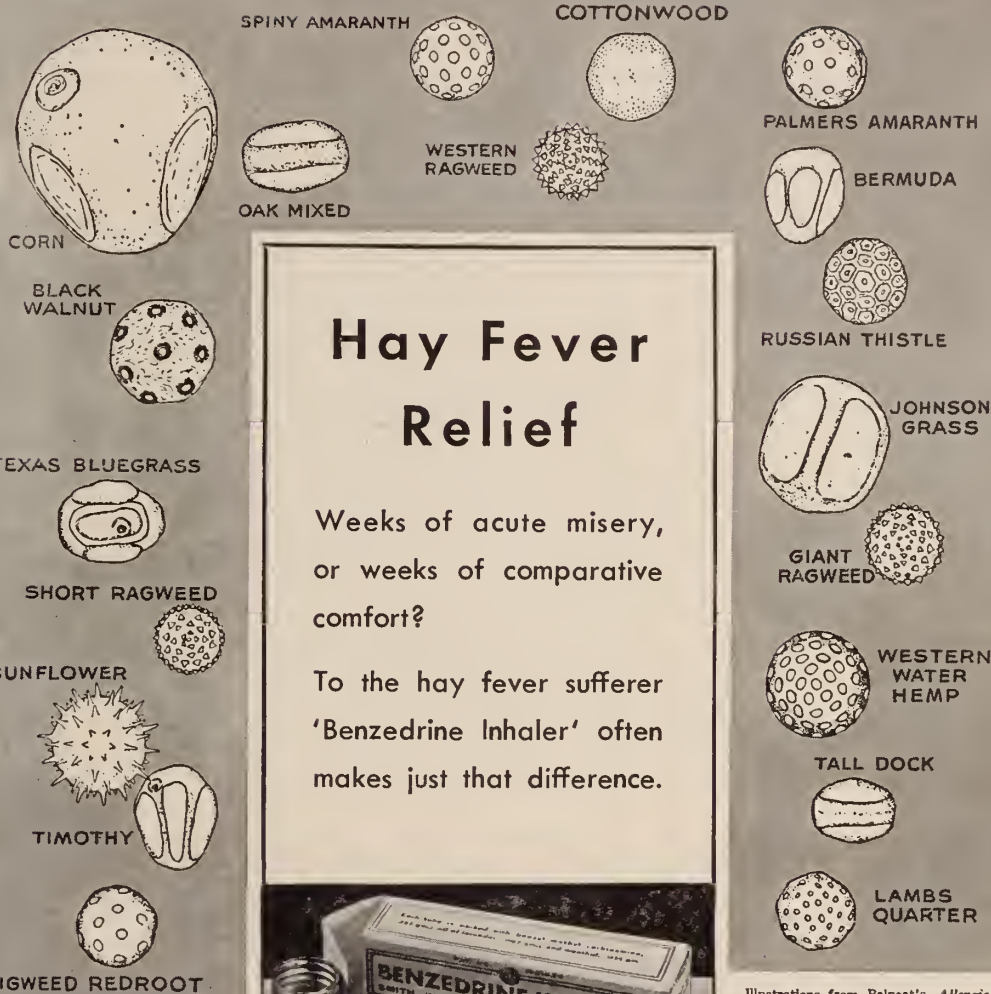
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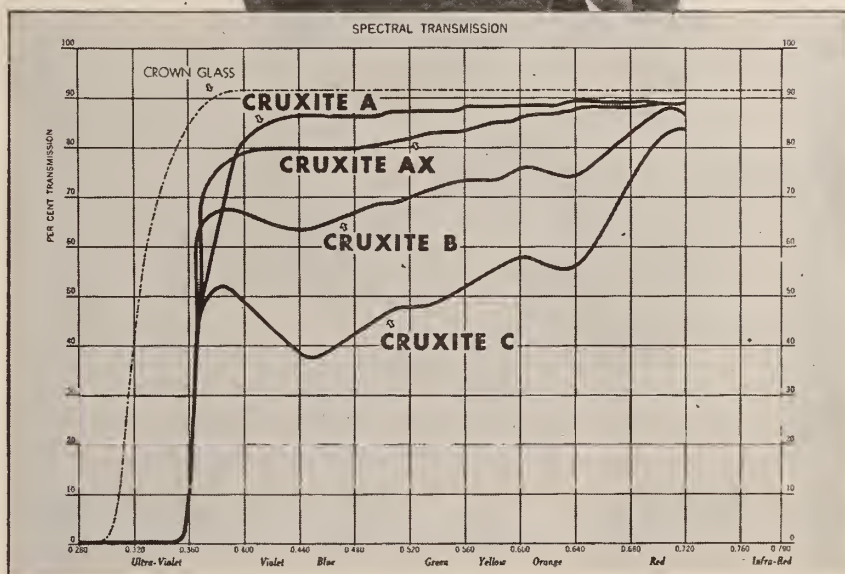


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## ECTOPIC PREGNANCY\*

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The subject of ectopic pregnancy was selected because it affords an opportunity to review and present a few interesting and somewhat unusual cases. These are all my personal cases, operated on during the past few years, and present both the usual and some unusual findings in diagnosis and differentiation of misplaced conceptions, including one lithopedion.

It appears that the first recorded case of extra-uterine pregnancy was that of Albucasis, an Arabian physician, about 1094.<sup>1</sup> The earliest definitely known surgical removal of an ectopic fetus was by Primrose in 1594.<sup>2</sup> The first American operation was performed by John Bard of New York in 1759. This was to be followed by other surgeons over the country, notably Baynham.<sup>3</sup>

According to Schumann,<sup>4</sup> ectopic gestation occurs about once in every 300 pregnancies. Surgical clinics have observed an incidence of roughly 3 per cent as average occurrence.

The majority of cases occur in the ampulla of the tube, but the sperm may fertilize the ovum at any point from its origin, at the graafian follicle, all along the line to a normal resting place in the uterine cavity. Likewise, this fertilized egg may be arrested and continue its growth at any point along the above-mentioned course. Nidation at any given point may be due to factors which mechanically block its progress, or tend to favor an alien attachment. Obstruction alone of the tube is not enough, as has been shown by experimental ligation in animals after fertilization, wherein it has been found difficult to force an ovum to develop in a normal tube.

Mechanical impediments may be as follows:

(a) Chronic inflammation and adhesions of the outer surface of the tube, which distort the lumen.

(b) Tumors, such as intramural uterine myomata that press against the interstitial portion of the tube. It is known, however, that uteri containing many large and vari-sized fibroid nodules have become impregnated. I recall two such cases on the service at Good Samaritan Hospital.

(c) Inflammation that either destroys the cilia and interferes with the normal production of a "current" in the tube, or destroys wholly or in part some of the plicae with resultant blind pouch formation.

(d) Congenital deficiencies in the tubes.

(e) Tubal spasms.

Factors favoring alien nidation, irrespective of obstruction, are due to decidual reaction stimulated by the corpus luteum hormone, or endometrial transplants in the tube.

When the fertilized ovum becomes implanted in the tube it is doomed to destruction—usually within the first three months—although the time element is not constant. The wall of the tube under the influence of the growth of the ovum becomes thinner and softer until rupture occurs. The rupture in turn causes death of the fetus and great danger to the mother. If the bleeding is free the hemorrhage may be fatal in a short time, but if slow a less dangerous hematocele may result.

Two main pathological terminations are recognized: namely, tubal abortion which is the most common, and tubal rupture. In tubal rupture the products of conception are discharged into the peritoneal cavity through a rent in the wall of the tube, and underlying external wall of the capsule of the ovum, and maternal blood flows freely into the abdominal cavity. If the nidation of the growing ovum has taken place in the mucosa, the ovum occupying a place within the lumen of the tube, expulsion through the fimbriated end of the tube usually occurs, constituting tubal abortion.

## SYMPTOMS

The subjective symptoms in ectopic pregnancy are not typical. Oftentimes the ab-

\*Read before the First Annual Meeting of the Southeast Medical District, Miami, Sept. 3, 1937.

sence of normal menstruation is the only indication of pregnancy to arouse the patient's suspicion. The usual signs of pregnancy are not marked. There may be an irregularity in menses with intermittent spotting and the passage of pieces of decidua. At times there will be an increasing feeling of uneasiness in the pelvis, with gradual evolution into a definite soreness and eventual attacks of pain due to peritoneal irritation, or escape of small amounts of blood preceding tubal abortion or rupture. In the absence of urgent symptoms which demand operative interference, these manifestations resemble those of subacute pelvic inflammatory disease associated with anemia. These are pelvic and lower abdominal pain, slight fever, leukocytosis and a moderate reduction in red cells and hemoglobin. They may abate and recur at intervals, giving rise to a "chronic" form of the disease; or, if it has been a case of early tubal abortion, the patient may go on to complete recovery and the fetal parts be absorbed, though complete absorption is not likely.

At time of abortion or rupture the symptoms are:

(1) Agonizing pain with faintness or syncope, the pain being continuous or intermittent.

(2) Upper abdominal distress, with nausea and vomiting.

(3) Often rectal symptoms and diarrhea.

(4) Occasionally severe pain in the neck and shoulder of the affected side. (Case No. 3).

(5) Added to these are usual signs of hemorrhage.

#### DIAGNOSIS

At the time of rupture the diagnosis in a typical case, with its sudden, sharp, lancinating pain in the abdomen and associated collapse together with a history of having missed one or more menstrual periods, may be relatively easy.

In the "chronic" type of case, a difficult diagnostic problem confronts the doctor. Ectopic pregnancy must be differentiated from threatened uterine abortion, or subacute pelvic inflammatory disease, or, in rare instances, a subacute appendicitis.

The primary consideration in differentia-

tion is, of course, to determine whether pregnancy exists. The uterus itself usually exhibits the reaction of early pregnancy, but not always to the degree that it can be recognized. In recent years a valuable adjunct has been added in the specific tests for pregnancy.

The microscopic examination of discharged portions of uterine decidua will tend to confirm pregnancy but will not differentiate between ectopic and early uterine pregnancy and abortion. Slight increase in leukocyte count occurs in ectopic as well as other pelvic lesions, but the inflammations as a rule run higher. The temperature is not reliable.

The most reliable method of differentiation after the existence of pregnancy has been determined, is a careful history, followed by painstaking pelvic examination. In a certain percentage of cases with subacute symptoms a careful observation over a period of a few weeks can be made and the diagnosis of a steadily growing tumor apart from the uterus definitely established. This is most valuable in the suspect cases.

Differentiation between uterine abortion and tubal abortion may be complicated by a prolapsed uterus and adnexa, or an inflammatory mass in the adnexa beside a uterus in normal position. Currettement of a uterus suspected of being pregnant, when the true condition is an ectopic gestation with inflammatory complication, can be fraught with danger. Cases far enough advanced can be submitted to x-ray. The family physician or the obstetrician can furnish much help from records of normal blood-pressure readings over a long period of time, a valuable aid in determining possible internal bleeding.

#### TREATMENT

Every case of ectopic pregnancy is a surgical condition that demands operation. In the acute rupture it is urgent as a life-saving measure. If a correct diagnosis can be made prior to rupture, operation is indicated as a conservative measure. In those cases of the so-called "chronic" nature, with hematocele formation, operation can be deferred as long as the general condition is improving and the symptoms subsiding, and occasionally absorption will be sufficient to forestall the need of an operation. But it is much better in these cases, when a doubt exists, to observe the dic-



tum of Holden<sup>5</sup> that it is better to operate and be wrong, than not to operate and be wrong.

#### CASE REPORTS

CASE No. 1. A white woman, aged 27, was admitted to the hospital on March 12, 1937, complaining of generalized pain in the lower abdomen for the past 24 hours. During this time she had two spells of vomiting, had taken no food except restricted liquids, and no purgatives had been administered. There were no missed menstrual periods, the last being 16 days in duration and ended two weeks prior to admission. On admission the temperature was 98.0°, and the pulse at 96 at 10:15 P. M. Pelvic examination showed the uterus and adnexa negative except for slight tenderness in the right side. Blood count—7,100 total white cells; urine normal. This patient had been sent to the hospital from an outlying section with a diagnosis of acute appendicitis, and a course of observation was decided upon. The following afternoon, her temperature had risen to 100.2° and pulse to 110, without any change in physical signs or subjective symptoms. An enema was given, which was followed by rapid improvement. Temperature and pulse returned to normal and the patient was discharged the following day. The discharge diagnosis was bilateral salpingitis, subacute.

This patient was readmitted on March 27, two weeks following discharge, on service of the same physician, at which time a tentative diagnosis of bilateral salpingitis and pelvic peritonitis was made. The history at this time brought out that after returning home from the previous admission she felt fine and had returned to work. Intercourse was consummated and was followed by gradually increasing pain and abdominal symptoms until readmitted to the hospital. On admission the picture was an entirely different one. The patient appeared markedly anemic; the abdomen was distended; pelvic examination was very difficult to perform and painful to the patient; pulse was 160; and temperature was 99.0°. There was dyspnea, almost to the point of air hunger; a slight spotting of blood came from the vagina. The blood showed 3,100,000 red blood cells and 50% hemoglobin, while there

was a total of 12,300 white blood cells, with a definite shift. Wassermann test was negative. The patient was treated for the general condition, by forced intravenous fluids and by transfusion of blood, during which she recovered from the acute symptoms. She was seen in consultation, when a diagnosis of bilateral inflammatory ovarian cysts was made, and operation was advised. The patient refused operation and was discharged as improved on April 14, 1937.

A third admission was made on April 28, the patient having decided on operation. She had improved considerably, but continued to have some abdominal distress, and persistent vomiting. The abdominal pain and vaginal bleeding had ceased, but she complained of occasional bleeding from the rectum and profuse diarrhea. Physical examination confirmed the presence of bilateral pelvic masses of the consistency of ovarian cysts and about the size of small oranges. The blood picture was 3,820,000 red blood cells and 9,400 white blood cells and no increased shift. Hemoglobin was 75%. Operation was performed for ovarian cysts of inflammatory origin, which were found as expected, enveloped in dense adhesions to the surrounding structures, and bound down in the cul-de-sac. Lying free in the pelvis, except for adhesions to the cecum was a cystic hematocele the size of a tennis ball, not previously recognized, which was also removed. The pathologist reported the hematocele on section to show degenerated chorionic villi and syncytium, warranting a diagnosis of ectopic pregnancy with tubal abortion. Sections of the ovaries showed inflammatory cysts. The left tube showed chronic inflammatory reaction, the right was normal.

*Impression:* This case presents the following features: history negative for cessation of menses; inflammatory pelvic disease associated with early tubal abortion coincident to intercourse.

CASE No. 2. This patient was a colored woman, aged 21, who had been married 6 years and had one child, living and well, 5 years of age. She had had no miscarriages. The significant history was that ever since the birth of her child she had suffered with pains in the abdomen that were supposedly gas



pains. Bowel action was only fair. Also, since childbirth the menses had been somewhat irregular, often appearing twice monthly. The present illness began about two weeks before admission to the hospital, and consisted of the same "gas" pains in more active form; she had not menstruated for four months. The family doctor had made the diagnosis of ectopic pregnancy. This patient was admitted to the hospital on Feb. 22, 1937, when a diagnosis of chronic salpingitis and probable abdominal pregnancy was made. Operation was performed on March 2, at which time on opening the peritoneum a thin-walled cyst about the size of a small grapefruit was encountered. It was of a dark green color and movable. Immediately posterior to this was a second mass with a thick gangrenous-appearing sac, densely adhered to the anterior rectal wall and the utero-sacral ligaments. During the delivery the thin-walled sac was ruptured and delivered a large quantity of clotted blood and a fetus, of between three and four months size. The patient recovered and was discharged on March 19th.

*Impression:* This case illustrates one of ectopic pregnancy with tubal abortion in presence of chronic pelvic disease.

CASE No. 3. A married woman, aged 28, mother of 3 children, living and well, was admitted to the hospital Feb. 13, 1934. For past three weeks she had had a slight, blood-tinged vaginal discharge associated with lower abdominal pains. On the morning of admission, while brushing her teeth, she became faint, spots appeared before her eyes and the abdominal pain became severe. She immediately had a copious watery bowel movement and felt slightly better, but on attempting to reach her bedroom everything became black before her eyes and she had to be assisted to bed. The abdominal pain remained intense and intermittent; vomiting ensued. Physical examination showed the abdomen to be distended and tender. The gentlest palpation produced excruciating pain, and any manipulation caused severe pain and spasms in the neck muscles of the right side. Vaginal examination disclosed a slightly enlarged uterus, a definite boggy in the right fornix, and a moderate amount of bloody vaginal discharge. Palpation of the cervix was extremely painful and invoked

again the spasms of the neck muscles. Albumin was 2 plus; R. B. C. 4,100,000; W. B. C. 13,600. At operation the abdomen was found filled with old blood, and a rupture of the right tube was found in the isthmal portion from which a sac about the size of a ripe olive protruded but had not been discharged into the peritoneal cavity. The sac contained products of conception and on section was reported to represent early placental formation. The patient was discharged on Feb. 24.

*Impression:* This case demonstrates clearly the shoulder and neck pains sometimes encountered in pelvic conditions.

CASE No. 4. A widow, aged 23, was admitted to the hospital, and operated upon immediately, on Aug. 16, 1931, because of acute abdominal pain. In summary, this patient had suffered intermittent periods of severe cramps in right lower abdomen for about three weeks, accompanied by constant slight discharge of blood from the vagina. She had not missed any menstrual periods but there had been marked irregularity. One week before admission she began to flow as at regular periods and the abdominal pain subsided. Twenty-four hours before admission she was taken with generalized abdominal pain which had become localized in the right lower quadrant by the following morning, or 12 hours later. W. B. C. count was 11,850; temperature was 100.4° and pulse 118. At operation a typical ruptured ectopic pregnancy was found in the left tube. Postoperative course was uneventful and patient was discharged on the fourteenth day. This patient was again operated on two years later for tubo-ovarian abscess on the opposite side.

*Impression:* This case is cited to illustrate the typical case of rupture.

CASE No. 5. This was a married woman 37 years of age, mother of 4 children, giving the following history: menses last on Jan. 15, 1933; 10 days previously she had begun to suffer with pains in the lower abdomen, intermittent in character. She took several doses of quinine on the theory that she was pregnant and would attempt to abort. Also daily doses of epsom salts were administered. On the third day she became nauseated, vomited a number of times and had several involuntary stools. The pains continued. On physical ex-

amination the recti muscles were found to be slightly rigid in lower portion; there was marked tenderness over the bladder and in the right iliac fossa. Vaginal examination revealed a soft mass of boggy consistency in the posterior cul-de-sac and the right fossa. Urine showed a faint trace of albumin; white cells numbered 17,400, and red cells 3,660,000.

A diagnosis of ruptured ectopic pregnancy was made and the patient operated on, March 22, 1933, the day of admission. The abdominal cavity contained a moderate amount of loosely clotted blood and a soft mass the size of a large lemon in the right pelvis. The tube was found ruptured at the uterine end. Pathologic diagnosis was tubal pregnancy. The patient made an uneventful recovery and was discharged on April 7, 1933.

*Impression:* This is a typical case of rupture, illustrating rectal symptoms.

CASE No. 6. Mrs. E. McC., aged 30, married, was referred for surgery on July 16, 1936, after being seen by a colleague in his office that afternoon. The history was as follows: nine days previously patient had a severe cramping pain in the midline, below the umbilicus, with some vaginal bleeding the following day. A similar attack occurred on the day of admission. The office visit was made at 4 p. m., when the patient complained, in addition to the pain, of weakness, dizziness and swimming of the head. She had had irregular menstruation for the past three or four months. The pelvic examination done in the doctor's office had caused much pain and it was necessary to administer codeine for relief. The blood pressure before examination had been 120/80 and one hour following had dropped to 100/70. By 10:00 p. m. the blood pressure was further reduced to 80/60.

On admission the temperature was 98.6° and pulse 100; R. B. C. 3,225,000; W. B. C. 16,250. After preliminary treatment for shock and a transfusion of blood, she was operated on and a ruptured ectopic pregnancy of the right tube and a hematocele of the left tube were found. Patient was discharged from the hospital by ambulance on the ninth day.

*Impression:* This case demonstrates the possibility of pelvic examination as a cause of rupture of tubal pregnancy. It is also what

might be designated as the "chronic" form of the disease.

CASE No. 7. E. G., colored, married, aged 22, came in complaining of a large tumor in the abdomen, which she wanted removed, and gave the following history: twenty-seven months previously she had been married while living in an adjoining state. The first menstrual period following marriage was missed, but the following period came on naturally at the proper time and each succeeding period was normal. Meanwhile the abdomen became steadily enlarged. One or more physicians were consulted and each one made a positive diagnosis of pregnancy. At the time of expected confinement, and likewise for weeks afterward, labor failed to set in.

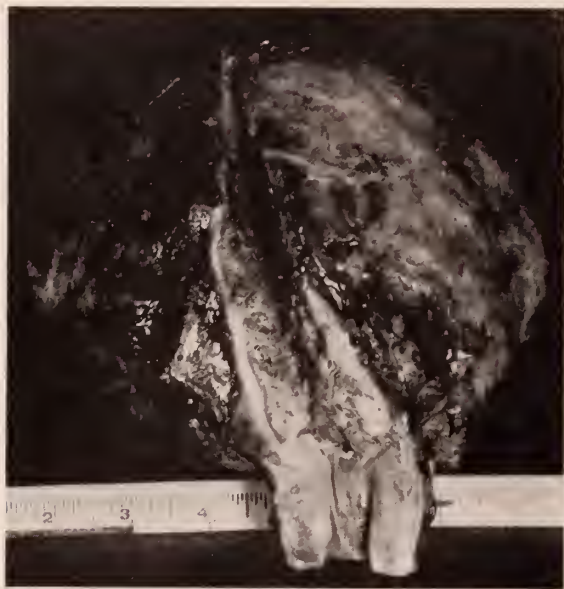
When seen by the writer the physical findings, except for the abdomino-pelvic, were entirely negative. Blood counts, urine, temperature and pulse were normal. Bimanual pelvic examination disclosed the presence of a tumor about the size of an 8-months' pregnancy. The abdominal portion was movable, smooth and of the consistency of an average fibroid tumor. The pelvic portion presented posterior to the cervix, well into the cul-de-sac of Douglas, and was composed chiefly of irregular bony prominences. The history and examination suggested a lithopedion, which was confirmed by x-ray. At operation an ovoid tumor mass was found arising from the right tube and attached to the uterus by a short pedicle formed by the tubal isthmus.



1. X-ray of tumor mass.



There were relatively few adhesions to surrounding structures. The pathologic report was as follows:



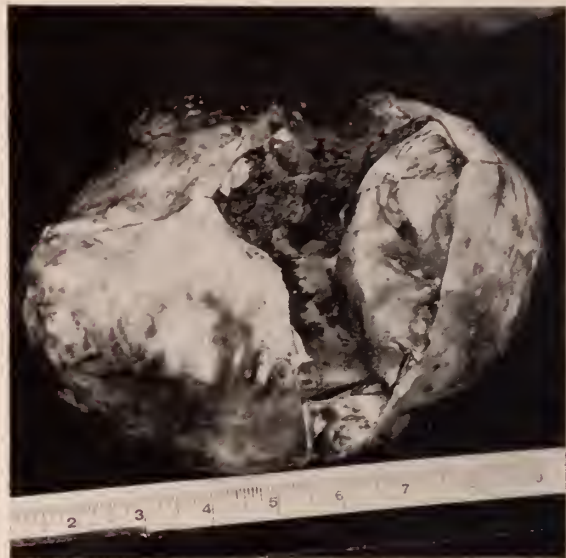
2. Section through anterior uterine wall.

"The specimen consists of the supra-vaginal portion of a uterus, to which is attached a large, roughly rounded tumor mass. The entire specimen weighs 6.25 pounds. The tumor is so formed and placed that the inferior portion of its wall replaces the supra-cornual portion of the uterine fundus. The endometrial cavity is lined with a smooth and glistening, thin, reddish-yellow endometrium. No connection is noted between it and the cavity within the tumor. The tumor measures 26



3. Section of tumor showing fetus and placenta.

cm. in diameter. Its anterior and superior surfaces are covered with thin, bloody adhesions, while its posterior surface is smooth and glistening. Its consistency varies from soft and boggy to firm and resistant. On section its wall is found to vary in thickness from 10 to 2 mm. At its uterine junction it is grossly indistinguishable from the myometrium. On section it appears dry and made up of longitudinal bands of light yellowish-gray tissue throughout which are many scattered areas of calcification. Within its cavity is found a much compressed, rather dry but well formed fetus. The state of preservation is remarkably good. The placenta is well formed and attached to the right inferior wall. It has a pinkish white color and spongy consistency.



4. Section of tumor mass, anterior wall, showing face.

Its surface presents many small calcified plaques. It sections with a gritty sound. No amnion is identified as numerous adhesions exist between the fetus and tumor wall. The umbilical cord is easily identified; after leaving the umbilicus it passes through the fetal legs and ends in an adhesive attachment to a calcified plaque in the left wall of the tumor."

The pathological diagnosis was: interstitial pregnancy of long duration with retained full-term fetus.

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## THERAPY IN MODERN PSYCHIATRY\*

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We, as physicians of varied branches of medicine, have dedicated ourselves to the high art of treating sick people, and regardless of our special interest in signs, symptoms, underlying pathology, or prognosis, we hold constantly focused in our attention this dedication to the healing art. And well you may ask of psychiatry: just what do you have to offer in the treatment of the mentally sick?

Just a few words about cases of psychoneuroses wherein the patients consult the general practitioner for relief. There are four groups under this heading, namely: anxiety states, hysteria, neurasthenia, and obsessive states.

The main bodily symptoms of the anxiety group occurring in order of their frequency are: insomnia, breathlessness, palpitation, general aches, anorexia, chest pain, lumbar pain, headache, epigastric discomfort and distention, general weakness, tremors and twitchings, dryness of the mouth, feelings of numbness and cold. This type of patient can often be recognized as soon as he walks into the consulting room. He looks anxious, distrustful and uneasy. In a jerky voice he describes his numerous symptoms. He feels that he may not be given sufficient time and attention. A written statement is often presented to the doctor in order to supplement his verbal description.

In contrast to the patient with anxiety states, as a rule, the one with hysteria looks quiet and unconcerned in spite of the most crippling symptoms. The mental attitude is unique and often leads to correct diagnosis.

The symptoms may simulate any bodily disease.

The classification of neurasthenia is often used as a dumping ground, even including mild cases of manic depressive psychosis. In a small number of cases of psychoneurosis, physical and mental fatigue form the chief feature: poor memory, inability to concentrate, poor sleep, anorexia, discomfort and aches of various parts of the body. The presence of organic disease does not rule out functional disorders; nor does the opposite hold true.

In times past it was thought that all that could be done was to lock patients up in asylums, prevent their injuring themselves or others, and look after their physical well-being. Gradually this attitude has changed until today a carefully planned course of psychiatric therapy is considered as essential as any form of therapy. It has long been known that drugs are of little value in treating the majority of mental disorders. However, the patient must often be built up and tonics and special diets are useful. Many other measures are used to build up the patient physically so that he is better able to cope with his nervous or mental disorder.

In psychiatric therapy two elements of great importance are: time and the removal of the patient from the family. The human personality has flowed endlessly and relentlessly to a catastrophe in a nervous illness. No one event can be ascribed as the cause; it is the culmination of one's life experiences. Therefore, it is impossible to correct in a few weeks or often a few months a personality or an attitude or a reaction to reality that has taken a lifetime to build up. The time element is just as important in psychiatric therapy as it is in the treatment of tuberculosis. We are not amazed that a tuberculous patient must spend a year in a sanatorium bed, but many people expect a nervous disorder to be corrected in a few weeks. Too often relatives become impatient, and since the patient has not recovered in a few weeks, decide they should try another hospital or give the patient up as a hopeless case.

The mental sickness has arisen in the family situation and it is essential that the patient be removed from this situation if he is to acquire a proper perspective, to regain his

\*Read before the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, Tallahassee, Oct. 21, 1937.

emotional balance, and to view things as they are. The precoc girl with the over-fond, over-attentive mother must be removed from this misguided devotion. The depressed husband must be removed from his aggressive wife, the obsessional wife must be removed from the husband whom she unconsciously sexually fears, the over-sensitive, unattractive girl must be removed from the attractive superior sister, etc. Trips to various cities accomplish nothing when the disturbing member of the family is the companion.

In hospitals for nervous and mental diseases hydrotherapy and occupational therapy have long been widely and successfully used. These measures are familiar to you and you have seen the direct beneficial results. Hematoporphyrin and sulphur in oil have been used widely as therapeutic agents in the psychoses. In epilepsy, adequate training and sheltered workshops are suggested as possible means of combating this disorder, along with the ketogenic diet; also the injection of methylene blue intravenously when a patient is in status epilepticus.

Sakel of Vienna and his followers report favorably upon many cases of schizophrenia after the popular insulin shock treatment. Best results are obtained in new cases, those of not more than two years' duration. Metrazal is also useful.

Progress is being made in the treatment of paresis, which was considered incurable up to fifteen years ago. Of five hundred eleven patients treated at the Philadelphia Hospital for mental diseases, 13.3% completely recovered, while 25.7% improved in some degree.

I come now to what I believe is the most important psychiatric measure that can be administered by the family physician, namely: psychotherapy—and this is the contribution of modern psychiatry to therapy. Several generations ago when it was decided that the insane were really sick people and not criminals, our insane asylums became mental hospitals, but they became hospitals in the sense that they concerned themselves with the physical well-being of the patient and little with the mental. Nurses were put in charge who were graduate nurses from general hospitals, psychiatric training being considered non-essential. The physicians devoted themselves to the

physically sick, because with the vast number committed to their care they had little time for the mental side of the illness. However, during the last few years a great impetus has been given to the study of the psychic illness of the patient.

Psychotherapy consists of talking with the patient about his mental, emotional and behavior difficulties and by frank discussions endeavoring to arrive at an understanding of the process involved in the illness, and to achieve some solution. The patient is asked to talk frankly and freely of the things that are on his mind, to hold back nothing, and to feel that the physician is not sitting in judgment but is sympathetically attempting to treat a sick person. Often patients will come and talk for days without really disclosing the topic that they feel is the real cause of the difficulty. Finally the anxiety is sufficiently decreased and the sense of guilt lessened to the extent that they at last bring themselves to talk about the real worry. This is known as an established transference. The process requires time, but the results are encouraging. This is psychoanalysis about which all of you have probably heard much. It has been misrepresented, misunderstood, and exploited by the ignorant. It has been presented to the public at times by various cults and pseudo-scientists, the subject of articles in cheap sex magazines, and misunderstood at times by the members of the nursing and medical profession. It offers the most complete and thorough exploration of the psychic life and the greatest hope of permanent cure.

Psychotherapy teaches the patient to know himself by compelling him to play an active role in his own cure in contrast to other forms of therapy wherein he is entirely passive. It obligates him to divert all the forces identified with his symptoms to normal channels. It is a rational method of treatment in the psychogenic or situational mental states, but useless and even contraindicated in the organic and deeply deluded mental conditions. As a rule the doctor can do very little to rectify an unfortunate environment. But he can encourage the patient to face the facts and to choose the best possible ways to meet his difficulties. To one willing to expend both time and patience, it offers not only help to the patient but to the individual administering such ther-



apy. The patient is enabled to understand something of his own mental mechanisms, and to acquire a tolerance for himself that makes life more endurable.

## GONOCOCCAL PERITONITIS OF THE UPPER RIGHT QUADRANT\*

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The occurrence of atypical attacks of diaphragmatic pleurisy or cholecystitis in young women who have attacks of pelvic peritonitis of gonorrheal origin or who have recurrence of such infection has often been noted. When following closely on an acute attack of pelvic inflammatory disease, such symptoms are quite annoying to the patient and a diagnostic problem to the physician as cholecystitis and operation may be considered and uselessly performed.

In 1930 Curtis<sup>1</sup> called attention to the frequency of occurrence of adhesions between the anterior surface of the liver and the anterior abdominal wall in women operated on for pelvic conditions of gonorrheal origin such as salpingitis, tubo-ovarian disease, hydrosalpinx, pelvic adhesions, etc. He described them as "violin string" adhesions, and suggested that gonorrheal infection in the female is not so strictly limited to the pelvis as has been supposed. Therefore, the occurrence of symptoms suggestive of cholecystitis or diaphragmatic pleurisy on the right in women who have gonorrhea should be considered as related to the gonorrhea and operations avoided.

In June, 1934, Fitz-Hugh<sup>2</sup> reported three cases of acute gonococcal peritonitis of the right upper quadrant. The first case, diagnosed as cholecystitis, was operated on but a normal gallbladder found. Smears of the exudate from the drainage tract showed intracellular, gram-negative diplococci. Two other cases with similar symptoms and evidences of gonorrheal pelvic disease were diagnosed on clinical evidences only. The picture is fairly typical but, of course, in the cases not operated on, absolute bacteriological diagnosis is not possible.

Sometime after a generalized gonorrheal pelvic infection (or re-infection) there occurs

an acute, severe pain of the right upper quadrant of the abdomen or the lower rib margins. The pain is anterior, does not radiate, and is fairly constant. It may simulate closely acute cholecystitis or diaphragmatic pleurisy. A diagnosis of empyema of the gallbladder may be made. The pain is not much affected by deep breathing but is worse when coughing, straining, twisting, sneezing or laughing are attempted. The erect position makes it worse and to lie flat on the back sometimes causes it to seem more severe. There is generally fever over 100° in the acute stage and a slight leukocytosis. Adventitious sounds are not heard in the chest, but in some cases a rough, "crunching to and fro" type of friction sound may be heard over the lower rib margins and the anterior abdominal wall, especially as the process begins to abate. The anterior abdominal wall is quite sensitive and the musculature spastic or even rigid. Peristalsis and bowel activity are not impaired but abdominal distention, chiefly upper abdominal, may be present. After the acute stage the symptoms may rapidly disappear or they may subside gradually and go into the chronic stage in which a dull, dragging ache in the right upper quadrant is the chief symptom.

In the differential diagnosis, pleurisy, pneumonia, pleurodynia, cholangitis, cholecystitis, cholelithiasis, colitis, appendicitis, peritonitis, duodenal ulcer, "intestinal flu," and herpes zoster must be considered and ruled out. The treatment is symptomatic, with bed rest imperative.

The condition probably occurs much more frequently than has been diagnosed and it is the purpose of this paper to report two cases.

CASE 1. Mrs. A., aged 30, divorced, was first seen on May 20, 1934, because of burning and frequency of urination. One week later there was a profuse leukorrhea, a creamy, white-yellowish discharge in which were demonstrated innumerable intracellular, gram-negative diplococci. (It was definitely known that she had been exposed to a man who had for three weeks been under treatment for gonorrheal urethritis). One June 4, after her menstrual period had begun, she developed a high fever (103°-104°), a leukocytosis of 23,000 and had all the symptoms and signs of an

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acute pelvic gonorrheal infection. Under absolute bed-rest, sedatives, nursing care, and frequent and copious hot douches she improved. Her temperature gradually fell to normal, and the pain and tenderness in the pelvis slowly disappeared. On June 20, she was temperature-free, there was little discharge, and movement of the cervix on vaginal examination no longer caused pain.

On June 24 she suddenly developed a severe pain in the right upper quadrant of the abdomen, "under the ribs." It did not radiate. It was in the midclavicular line, was aggravated by moving, sitting up, twisting about in bed and crying. The whole right upper quadrant was exquisitely tender to touch and rigid to palpation. The temperature was 102° and she had a leukocytosis of 12,300. No friction rub was heard, no pleuronic signs developed, the gallbladder was not palpable and the only abdominal symptom or sign other than mentioned was an annoying, generalized distention. By June 28 the temperature was again normal; the pain and distention were gone and only a dull ache and slight sensitivity under the rib margin remained, but now one could hear a loud, rough grating friction sound over the right upper quadrant when the patient took a deep breath. A cholecystogram on the 30th showed a normally functioning gallbladder.

On July 2, there was another flareup of the pelvic condition which required three weeks to subside, but the signs in the upper right quadrant had all disappeared by July 10 and did not recur. There have been no symptoms such as these since then. Since August 1, she has had discharge only two days before each period to remind her of the pelvic infection.

CASE 2. Mrs. B., aged 28, married, was first seen on November 20, 1934. She had been suffering for the past four months with backache, loss of appetite, fatigue, and a persistent profuse discharge. She had been to a number of clinics for treatments of the cervix and had been told that she had a "tubal cyst" on one side. The previous summer she had been in bed with fever and low abdominal pain on the left side. Occasionally she had some burning on urination, but the profuse discharge was the most troublesome of her complaints. The cervix was enlarged, and showed a small laceration. It was quite red

and edematous and movement of it caused pain in the pelvis. Both tubes could be palpated; the one on the left was rather tender. She denied ever having had gonorrhea but repeated searches of smears from her cervix showed occasionally an intracellular, gram-negative diplococcus.

On November 13, she was suddenly seized with a severe pain in the right side. It did not radiate but was felt all over the lower ribs anteriorly. It was increased by deep breathing when she also felt pain on top of her right shoulder. Her pain was aggravated by walking, sitting, laughing or twisting. The upper right quadrant was spastic, but not extremely sensitive to touch unless the fingers were pushed under the rib margins. She had no intestinal symptoms, no distention. She had a normal temperature when seen on November 20 but had 102° on the 13th. Leukocytosis on the 20th was 9,000. The gallbladder was never palpable and she had no adventitious sounds in her chest. In this case there was not heard any loud, rough, friction sound. The patient did not continue in bed in spite of continuance of her pain. Adhesive strapping did not help at all. Sedatives and heat to the abdomen gave relief, but when on her feet and walking she continued to have a dull, aching pain in the upper right quadrant which slowly subsided until December 12 when she was relatively symptom-free except for her discharge and slight pelvic discomfort. She had a similar attack of right upper quadrant pain in Chicago, at which time (July 1934) she had a normal cholecystogram. This patient's symptoms were at no time as severe as those in Case 1, but both were sufficiently clear-cut and definitely related to a pelvic gonococcal infection as to leave no doubt as to the diagnosis.

#### SUMMARY

1. There is a definite clinical entity, a complication of gonorrheal pelvic disease in women, which is more common than is realized, and which has been called gonococcal peritonitis of the right upper quadrant. It is a condition simulating acute cholecystitis or diaphragmatic pleurisy associated with previous or subsiding pelvic disease. It is non-fatal and manifested by definite symptoms which can be recognized.

2. It terminates in adhesions between the anterior surface of the liver and the anterior abdominal wall. These adhesions are of the "violin-string" type as described by Curtis.

3. Two cases are reported, one a severe sequel to an acute pelvic infection, the second a mild recurrent attack associated with chronic pelvic infection.

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Dreka Bldg.

### COOPERATION OF RAILROAD SURGEONS\*

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For the sake of convenience I have subdivided this subject under the following heads: Qualification for a Railroad Surgeon; Brief Resume of Railroad History; The Duty a Railroad Surgeon Owes to his Company; The Duty a Railroad Surgeon Owes to his Community; The Medico-Legal; and The Assistance that the Railroad Surgeon can give both to the Railroad and the Public.

#### QUALIFICATION FOR A RAILROAD SURGEON

He must be a temperate man, and in using that word temperate I do not confine the meaning to alcohol. It is just as necessary that he be temperate in regard to eating, sleeping, exercise and habits in general.

He must be qualified in his profession, and this qualification takes in more than the mere knowledge that he gains in medical schools, hospitals and from books. The right type of man must be level-headed, aggressive, sincere, love his work, and in addition to this, give his time, thought and attention to his work.

He must keep his own self-respect and in doing this he is in position to demand respect from others.

He should make his reports to the central office so that the office will have a word picture when the report is read. You know the central office frequently has to pass upon questions on the report of the surgeon alone with no other history. Please make that report as concise and to the point as possible,

but at the same time cover the subject from all angles.

A railroad surgeon should be an outstanding man in his community, a leader in civic affairs, as well as having a high professional standing. His honor and integrity should be above reproach and his veracity unquestionable.

He must keep himself in good physical condition. This is a duty he owes himself, his family, the railroad company and the public at large.

He should be fair, impartial and thorough in his reports of accidents. No railroad company wishes any of its personnel to misrepresent facts for them or misrepresent conditions to them.

#### BRIEF RESUME OF RAILROAD HISTORY

In 1802 Richard Trevethick took out a patent for a wheeled engine which should run on rails by its own power. In 1814 George Stephenson built a locomotive and put it in operation near Killingsworth, England, demonstrating that a smooth wheeled engine on smooth rails could draw loads up hill. The Manchester and Liverpool Railway was opened for passenger and freight traffic in 1830. These happenings all occurred in England. The first railway built in the United States, especially for the purpose of steam traffic, was the one begun in South Carolina in 1830. As a matter of fact the beginning of railroads was the beginning of modernization of the world, as without railroads you cannot have mass transportation, mass production or mass distribution, and without these three essentials we would never have progressed to the point where we are today.

The principles that George Stephenson advanced in his engine, The Rocket, were sound then and are sound today. If it had not been for the railroads blazing the trail, that vast section of the United States west of the Mississippi would still be a wilderness. If it had not been for railroads all the important industrial centers would still be prairies, because railroad transportation collects and hauls coal and oil to the factories, carries raw materials to the factories, and transports finished products to every hamlet in every State of the Union. Do you know that the railroads partake of the results of research of almost every producer of seventy thousand

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different items of materials, supplies and equipment, which they buy and use in the manufacturing of their products of service? Do you know that Thomas Edison, the electrical wizard, got his start in the railroad business, and that Walter Chrysler and Vinson Bendix, of automobile fame, learned the mechanical trade in railroad shops?

Railroads do not manufacture articles to sell to consumers; they buy things and combine them to produce a service which they sell. The approach of railroads is different from that of a business which makes and sells products, and which may in fact make a considerable part of this year's profits by outmoding the products of last year in the hands of the consumer. The problem is totally different, too, in that everything now introduced to a railroad must fit in and work right along with what is already there. The automatic coupler, for example, could not be introduced in a practical way until it was so developed that it would work interchangeably with any one of the several sorts of hand operated couplers then in use. Everything on a railroad is part of one great organization of men and machines operated for the production of a service. I use this purely as an illustration of the word cooperation. Do you know that three years ago six railroad companies, two universities, and ten supply houses, alone had more than one thousand men engaged in research on railroad problems, and since that time the number has increased? Management, labor, and the public, all three, have a vital interest in railroads, and all three should work together for the common good of all concerned.

In the history of the building of railroads the surgeon was just as necessary as the construction engineer or any other official. Without the advice of the surgeon on sanitation, epidemics and keeping the health of the forces used in construction work in good condition, no railroad could have been built. In support of this statement I call your attention to the Panama Canal. As you know, this undertaking had been tried before by at least two different countries and they failed, because of the sanitation and health conditions, until two great men, one an engineer and one a physician, together worked out a plan whereby the health and sanitation of the workers were made safe.

As a result of the work of Gorgas and Goethels the Panama Canal was made a reality. This same type of cooperation between engineers and doctors made possible the building of all railroads.

I would like you to make a mental picture of the early railroads, their tracks and equipment, and note today the wonderful locomotives, the air conditioned coaches, the rock ballasted roadbeds, the automatic block signals, the pleasure and comfort of sleeping, the splendid meals in dining cars, the high speed of both passenger and freight trains, and to take into consideration the number of trains running daily with all the obstacles that are placed upon the railroads, such as weather conditions, road crossings, etc. As you know, it is now not a railroad crossing any more, but an automobile crossing over railroad property. With these obstacles in mind, it is really remarkable how close to schedule time the trains run. At the same time, I wish you to have a mental picture of the medical profession in 1812, and see what progress they have made from the old days when the barber was the surgeon, when no antisepsis or asepsis was used, to the present day set-up of your Mayo Clinics, your Johns Hopkins Clinics, your Crile Clinics, your Lahey Clinics, your Tulane Clinics, and others too numerous to mention. Cooperation has been necessary in our own profession, both within its own ranks, with the public, and with corporations like railroads who have helped to make the progress possible. Railroads carry and safely transport physicians to distant medical centers for special study and work. They also carry safely and with every convenience transport your patients to centers that are especially equipped to handle certain types of cases.

#### THE DUTY A RAILROAD SURGEON OWES TO HIS COMPANY

Times and customs have changed. We have gone forward and in going forward the railroad surgeon has had to keep pace with the forward movement. I am outlining a few points that are pertinent to these changed conditions.

The treatment a railroad surgeon renders an injured patient is public property and his method and type of treatment is frequently aired in court, so that a railroad surgeon in



rendering correct, efficient and courteous treatment to an injured person not only serves the railroad but usually makes a friend of the patient and the patient's family, and thus opens up a legitimate avenue for future private work.

In addition to being qualified from a professional standpoint he must be prompt and comprehensive in his reports, give a fair, accurate and thorough account of his physical findings, including those conditions which in his opinion were caused by the accident and also all abnormal conditions that are found which, while in his opinion they have no connection with the accident, the knowledge of them will be of inestimable value to the railroad company at a later date.

The railroad surgeon should stay strictly in his own profession and properly treat the injured. He should not try to furnish the necessary medical and surgical treatment to an injured person and at the same time act in the capacity of a claims adjuster, because if he does assume this dual role, both he and the company lose in the long run, as the patient loses confidence in the surgeon and that hurts both the surgeon and the railroad company. If the surgeon does assume this dual role while he is still attending the patient professionally, he frequently loses his professional equilibrium, his mode of treatment sometimes will be changed, due to the reaction produced on the patient when the surgeon while treating him professionally attempts to inject the settlement of the case into his treatment. After he has finished treatment it is his duty, if and when called upon by the Claims Department, to assist them in any way that he can, and this, at this time includes rendering them assistance in the settlement of the case, but never under any circumstances trying to handle the case professionally, and at the same time handling the claim end also.

The surgeon should be frank and fair in talking to the patient. However, he should carefully weigh his words in talking to an injured person as the patient frequently is apt to interpret the expressions of a railroad surgeon to suit his own situation and condition. Remember, that an injured patient frequently will have a wonderful memory of what you said when you first saw him and this sometimes in the future is embarrassing to doctors.

Don't be either too optimistic, or too pessimistic, as either extreme places your company in an embarrassing position. Examine your patient thoroughly, completely and conscientiously. This type of examination will be beneficial to the patient, your company and yourself. If you are too optimistic at first and find out a little later that some serious complications develop in your patient, you destroy the confidence of your patient and bring criticism on your company and on yourself. If you are too pessimistic about the future of the patient, you create an unnecessary hazard for the company and frequently sow seeds in a fertile ground that are expensive to the company in court later on. In addition to these facts you produce disastrous results on the patient himself, not only with regard to your immediate treatment, but also to his future wellbeing. Psychologically, this will play an important factor. Be thoughtful, fair, frank, impartial and conservative in expressing your opinions. Above all, never fail to acquaint the company with expected bad results as well as expected good results in all cases.

#### THE DUTY A RAILROAD SURGEON OWES TO HIS COMMUNITY

First, that he keep his physical and moral condition up to the standard at all times.

Second, that he be up-to-date, especially with reference to his profession, and also up-to-date in civic affairs for the good of his community.

Third. He must be careful, considerate, broadminded, and primarily devoted to his profession.

Fourth. Such a man will necessarily be civic minded.

Fifth. To conduct himself both personally and professionally so that he will be loved and respected and live so that his honesty, integrity, veracity and ability will not be questioned.

#### THE MEDICOLEGAL ASPECT

In talking about the medicolegal side of the railroad surgeon I wish to emphasize the following points:

You have thoroughly and completely examined the patient, unless, of course, you are going to testify purely as an expert and testify only on hypothetical questions.

In advance of going on the stand, you

should have several conferences with the railroad attorneys and go over in detail the claims made by the plaintiff, comparing the alleged injuries with the facts found at your examination. Compare also the present condition of the plaintiff with the type of injuries received and frankly discuss your views with the attorney. Above all, give the attorney the dark side as well as the bright side of the situation from a medical standpoint, as it is much better for both to thoroughly understand the situation before you get to the court room. Thoroughly prepare yourself about the condition you found at the time of the accident, the present condition of the patient (if you are allowed to examine the patient at this time), and the ultimate result that more than likely will follow a severe injury. Do not trust to memory; but put down all your findings as you examine the case and do not wait until you get back to the office for this important feature. Also put down the date of examination, where made, and who was present at the time of examination. Again let me emphasize the importance of a thorough and detailed examination, noting all conditions found that are abnormal whether relating to the accident or not. Also remember to be very careful in expressing your views of the case, as unfortunately, due to the stress of excitement immediately following an injury, the patient and the attending public at any scene of an accident will be very apt to distort what was said by the physician.

On the stand, never lose your self control. If you have prepared yourself beforehand and have consulted frequently about the case with the attorneys who engaged your services, you need have no fear of proper examination by the other attorneys. If your examination is improper the attorney who engaged you and the judge will handle that part for you. Use as few technical phrases as possible; use a language that the judge, jury and attorneys will understand and you will have less chance of being severely cross-examined by the opposing counsel. Answer the questions asked you as much to the point as possible without including in your answers subjects not relating to the questions asked. Finally remember that you are a doctor and not a lawyer, that the company and the Court expect you to give an honest and truthful reply to the medi-

cal questions asked. Then it is up to the legal profession to apply the medical knowledge that you have given them for the further handling of the case. The medical witness frequently makes or breaks the case by being too partial in his statement of theories and not the facts in the case, and also allowing the jury to think he is too one-sided in his views if he is employed by a railroad company. Develop a reputation for being frank, fair, impartial in your remarks, thoroughly versed on the subject you are being examined on, and you will be successful. Never be afraid to answer "I do not know."

#### THE ASSISTANCE THAT THE RAILROAD SURGEON CAN GIVE BOTH TO THE RAILROAD AND TO THE PUBLIC

A railroad surgeon of the type that I have described occupies an enviable position in the personnel of the railroad company, and is a benefactor to any city or community that is fortunate enough to claim him as a citizen. A surgeon of the type described can be of valuable assistance to the railroad company in many ways.

In any city or community of 5,000 or less inhabitants with the exception possibly of the agent, the railroad surgeon should be of more value to the railroad company than any of the railroad personnel located there. His education and followup study makes him above the average of his fellow men. His professional ability, his knowledge of human nature and his knowledge of personal, financial and political affairs of people in his city, make him of valuable assistance to the railroad company.

His reputation as a man and a physician, his knowledge of political and financial conditions of the people of his city, coupled with the broadminded sympathies and understanding viewpoints from which the physician analyzes conditions, make him an outstanding man, and a man in a position to render assistance to both the railroad company and the people in his city. Regarding the assistance that this type of man can give to the community, I beg to call your attention to the following: He serves the rich and poor alike. He is, as a rule, an outstanding man in civic, fraternal, financial, and political affairs. Primarily, he has a good education, and this ad-



vantage is enhanced by keeping abreast of the time in his own profession, and, due to the close intertwining of his own profession with the affairs of the world, he keeps pace with the affairs of the world as a whole. The teaching of a physician, and the daily application of these teachings in his professional work, make him analyze situations, not only from a professional standpoint, but also from a general standpoint, and thereby gives his community the benefit of a trained analytical mind to help solve its problems.

A physician, then, with these qualifications, is necessarily placed before the public and the public is entitled to the benefit of his analytical mind. To fulfill this obligation, it is necessary for the physician to keep thoroughly abreast of the times and to study the general conditions that affect his City, County, State and Union. In this connection, I would like to present for your consideration a few facts concerning the railroads and the public. All the railroads of the United States have an investment of practically twenty-five billion dollars. The stocks and bonds of the different railroads are owned by hundreds of thousands of investors in all walks and stages of life, by trust companies, by insurance companies, banks, widows and orphans. Do you know that the railroads have to buy, maintain the upkeep of, and pay the taxes on, all their equipment, roadways, depots, terminals, warehouses, etc., and in addition in most states, the railroads have to pay a license or a franchise tax? That the railroads themselves employ over one million people, not counting any of the allied industry employees? Have you thought about the fact that the railroads in the United States paid in 1934, \$323,590,571.00 in taxes? That in the great commonwealth of the State of Florida the railroads paid out in 1934 \$3,039,067.00 in taxes? That of every dollar paid in taxes by the railroads throughout the United States approximately 45 4-5 cents is utilized for school purposes? Do you know that according to statistics the average cost per pupil in average daily attendance in schools in the State of Florida is \$48.92 per year? Taking the figures of the taxes paid by the railroads for schools in Florida and basing your figures on current expenses per pupil, you have an

estimated number of pupils educated at railroad expense. A little figuring will show that 9.62, a fraction below 10% of the total number of school children in average daily attendance in the great State of Florida are educated with railroad tax money. So you can readily see, gentlemen, that if the railroads were to revert to Government ownership what a tremendous loss in money it would be to your fair State and what a terrible blow to the educational advantages of your children and mine. Have you thought about the many unfair tactics that are used against railroads, and not against their competitors?

Traffic rates are practically controlled by the Interstate Commerce Commission, as far as the railroads are concerned, but yet up to now the busses and trucks use our State roads, and with their heavy loads destroy our wonderful highways which have been built with the taxpayers' money and in which the railroads have been large contributors, and these same busses have had no restrictions placed on them with regard to equalization of expenses in carrying on their competitive work against the railroad company that has to build and maintain, and pay taxes on, all of its roadway and equipment.

In railroad work the employee works under carefully supervised, orderly, regular and limited hours on property owned by the railroad company on which the railroad company pays maintenance, upkeep, and taxation after it has had a very heavy initial investment. The employees of railroad companies receive fixed salaries, or are paid fixed wage rates coupled with working rules which permit them to earn compensation generally higher than is paid in other lines of industry. Do the carriers who run in opposition to the railroad company buy their own rights of way, maintain their upkeep, pay taxes on them, have the same wages, hours of work, and employ anywhere near an equal number of employees as do the railroad companies, with equal ratio of service rendered? I leave the answer of this question to your own judgment. Is it fair for the Government to regulate and legislate railroads practically out of existence, to make the railroads build their own railways, equip their trains



according to Government requirements, to make traffic rates, both passenger and freight, under Government supervision, and then make the railroad companies compete in rates with such subsidized Government agencies, as barge lines, water ways and canals that pay no comparative taxes to your City, County, State or Union, but on the other hand, take millions annually from the taxpayers of the United States for the upkeep and maintenance of these subsidized agencies? I ask you again is that fair competition? Take, for example, the six-foot channel on the Missouri river at Kansas City. Millions upon millions of dollars have been spent on the six foot water channel during the last quarter of a century, and now at last the people of Kansas City are promised a boat every ten days, and the water way corporations are trying to force the railroads to grant rail rates equal to river rates with this promised ten day boat schedule. Is this being fair and equitable? I could stand here for hours and give you similar conditions that exist over the United States, conditions in which privately owned railroad companies are having to compete daily with subsidized Government agencies.

For one hundred and forty-seven years the people of the United States have lived under a constitution which was put in operation the first Wednesday in March, 1789. The wise men who drew up this constitution, realizing the many pitfalls that might follow along with it, made it so that the powers granted by the constitution are divided into three parts: the Legislative, the Executive, and the Judicial.

It is the purpose of the Legislative part of the Government, which is Congress, to enact the law; the Executive branch, under the direction of the President, to enforce the law; and the Judiciary, which is the Supreme Court, to construe the law, but neither of these branches of the Government has any power under the constitution to encroach upon the other. The Government of the United States

is one of limited power. The Congress has only such power as the people of the States have granted to it under the constitution. All other powers are reserved to the States or the people thereof. Necessarily, therefore, it is essential to the protection of the national jurisdiction and to the reserved powers of the States, that the final decision upon which all questions arising in regard to the constitution of the United States shall be vested in, and be decided by the Supreme Court of the United States.

It is these three branches of our Government that have led us from a wilderness up to the present time. It is these three branches of our Government that will stamp out fascism, communism, and bolshevism, and leave us with that grand old bulwark of safety, Americanism. Now, gentlemen, cooperation is the key-word in stamping out these un-Americanisms and un-American tactics and it is up to you gentlemen with your broad analytical minds to appraise frankly, fairly and impartially the acts of your City, County, State and the United States legislative bodies. If you, as Railroad Surgeons, will carefully weigh these matters you will see to it that the largest industry in the United States, viz., the railroads, are given a fair, square deal and in my opinion you will have fulfilled the requirements of cooperation of railroad surgeons.

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#### RELIEF OF PAIN BY INTRASPINAL (SUBARACHNOID) INJECTION OF ALCOHOL\*

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The purpose of this paper is to present a comparatively recent development in the relief of excruciating pain of a chronic nature. There is a large number of patients with chronic diseases, both benign and malignant, whom it is impossible to cure. However, this group merits at least relief from pain. Furthermore, the relief of severe pain may permit more intensive x-ray, radium, or other treatment, which otherwise could not be tolerated.

The subarachnoid injection of alcohol for

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the relief of pain was first reported by Dogliotti in 1931 and since this time there has been an increasing interest in the use of alcohol intraspinally. Where pathological lesions causing severe pain cannot be corrected by proper surgical or medical means, the profession has had to resort to the liberal use of narcotics, or to open operative procedures on the peripheral, sympathetic, or central nervous systems. This method affords relief to many of the so-called "hopelessly incurable"; prevents them from drifting into the hands of quacks, and makes life at least more tolerable.

Many typical case reports have appeared in the literature in the past six years in which the intraspinal injection of alcohol has been used for the relief of the intractable pain of cancer, aneurysms, and the peripheral vascular diseases. More recently the method has been used in less hopeless conditions such as chronic arthritis, sciatic neuralgia, angina pectoris, bronchial asthma, pruritus, and intractable hiccupping.

To understand the principle on which this method is based it is necessary to consider briefly the physics of ethyl alcohol in the subarachnoid space. The specific gravity of ethyl alcohol 95% is 0.806 to 0.810. It is much lighter than cerebrospinal fluid, whose specific gravity is 1.007. One can therefore float the alcohol upon the cerebrospinal fluid, and by having the patient flex the spine laterally, limit the spread of the alcohol to a particular segment.

Briefly, the technique for the subarachnoid injection of alcohol is as follows: The roots to be bathed in the alcohol are best determined by reference to charts with the innervations of the various structures which may be affected. Extreme care must be taken to place the patient in the correct position, with the center of the area to be affected uppermost, in the horizontal level. Keep the patient's head lower than the part of the spine which is to be injected. Under strict asepsis a fine lumbar puncture needle is introduced into the subarachnoid space at the level of the root most involved. Obtain free, clear spinal fluid. The dose of the alcohol should be between 4 and 16 minims of sterile absolute or 95% ethyl alcohol. Alcohol taken at random may contain spores. Sterile alcohol filtered and boiled under pressure can be obtained in ampoules.

Three to four minutes should be taken to inject the alcohol by means of a tuberculin syringe. No attempt should be made to draw spinal fluid into the syringe to mix it with the alcohol, as this is exactly what is not wanted.

Following the injection the patient is kept from 10 to 15 minutes in the same position with the utmost care being taken to keep the head low. Then turn the patient flat on the back with the foot of the bed elevated from 4 to 8 inches. Keep the patient in this position for two hours, well covered and protected from draughts. The head may be elevated after this, but the patient should not sit up until four hours after the injection. For bilateral pain, inject first the side which pains more and repeat in six days to affect the other side. It is impossible in a paper of this sort to treat adequately all of the technical details and anatomical structures which must be considered in a procedure of this type.

When the alcohol injection is well localized to the roots involved the clinical observations are usually as follows: the pain is immediately relieved and a sense of warmth with some numbness following is the rule. Occasionally, complete relief is not experienced from one to seven or more days after injection. The patient can always move the leg or arm, although it may continue to feel "asleep" for several days. Sensation of superficial touch, pain, tactile discrimination, and temperature sense are lost. Sometimes a sharply demarcated cutaneous erythema is noticed.

Stern, who has contributed much to the development of this method, reports no loss of muscle, tendon, or joint sense; no loss of equilibrium; no loss of automatic control of muscles; and no trophic ulcerations of any kind where the maximum safe dose of 16 minims of alcohol has not been exceeded. However, in one case where 30 minims of alcohol was injected into the tenth thoracic subarachnoid space, complete loss of muscle, tendon and joint sense and loss of lower limbs resulted.

Dogliotti reported the relief of pain up to six months. Stern and others report cases in which there has been complete relief lasting from one to eight months. Of Stern's cases 10 per cent were given no relief while, of the remainder, 70 per cent received complete relief and 30 per cent partial relief. In



many cases it is advisable to inject cautiously with rather small doses, repeated if necessary after six days. This method of "feeling" one's way to the exact nerve roots should be explained in advance to the patient so that he doesn't become discouraged if complete relief is not immediately obtained.

Injection of alcohol following the accidental puncture of the spinal cord or injury of the spinal blood vessels may cause complications. This can be avoided by not injecting alcohol if a slightly bloody cerebrospinal fluid is obtained, which doesn't clear after the removal of a few cubic centimeters.

More than 8 minims of absolute alcohol injected between the second and third lumbar vertebrae will invariably cause bladder complications. The bladder becomes distended and dribbling occurs from the overflow, with the possibility of resultant infection. Doses of alcohol larger than 16 minims in the third lumbar interspace may cause rectal incontinence. However, both bladder and rectal complications can be avoided by following accurately the details of technique and dosage and limiting the action of the alcohol to one side at a time.

In no case where the dose of alcohol has not exceeded 8 minims has there been any motor paralysis, although transitory motor weakness as occurs in spinal anesthesia, may be complained of when the larger doses are used. The possibility of complete motor paralysis and death with large doses of alcohol has been demonstrated experimentally in cats. Respiratory paralysis may occur theoretically if the head is not kept lowered immediately after the injection and the alcohol permitted to bathe the respiratory center in the medulla, but no such cases have been reported.

It is interesting to note that following an intraspinal alcohol injection the red blood count may increase as much as 2,000,000 per cubic millimeter in 24 hours and the hemoglobin increase 20 per cent. Furthermore, there may be an increase in the eosinophils as much as 12 per cent while the total white cell count remains unchanged. The exact cause of these changes in the blood picture has not been determined.

The following conditions are considered as contraindications to this procedure: infections of the spinal column not well localized; ex-

tensive bleeding cancers; diabetic or arteriosclerotic gangrene accompanied by spreading cellulitis; and polycythemia vera. In any obscure case injections should not be given until all methods of investigation have been tried. Spinal cord tumors especially should be kept in mind. The removal of pain as a symptom may make the diagnosis more difficult.

I have made no attempt to discuss the use of this method in the treatment of conditions such as sciatic neuralgia and bronchial asthma as the work is more recent and the reports less numerous. However, in cases of intractable pain where the usual medical treatments have been of no avail and surgery is contraindicated, this procedure has a very definite place.

The number of reported cases treated by the subarachnoid injection of alcohol is sufficiently large to warrant the conclusion that this is an efficient method of controlling pain in certain chronic and incurable diseases. The complications of the method are severe, but when successful the results justify the means, particularly in the group of so-called "hopeless incurables."

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**A. M. A. MEETING—SAN FRANCISCO**

There were more than six thousand physicians registered at the annual meeting of the American Medical Association, held in San Francisco the latter part of June. It was the largest meeting of physicians ever held on the Pacific Coast.

The continued expansion of the activities of the American Medical Association in the past few years has complicated greatly its scientific, professional and business relations and has resulted in passing on to the Board of Trustees and the House of Delegates a rapidly increasing and rather burdensome volume of work. At this meeting, sessions of 2½ full days were required by the House of Delegates for completion of its work and very much more time, in addition, was required for the work of the reference committees.

On pages 52 and 56 of the July 2 A. M. A. Journal will be found the reply of the House of Delegates to a message from Miss Josephine Roche, announcing the national health conference which was to be held in Washington, July 18-20.

Among the important activities of the House of Delegates at this session was the election of Dr. Rudolph Matas of New Orleans as the recipient of the Distinguished

Service Award. A resolution proposed by the New Jersey delegates, criticising some activities of the editor of the Journal of the A. M. A., was taken up in executive session. After a full hearing, the House voted unanimously to reject the New Jersey resolution and, in addition, gave the editor a special vote of appreciation and confidence in his activities.

Refusal was made to accept the proposal of the Michigan and California delegates, recommending that the House be granted power to spend funds of the Association, independent of the Board of Trustees, for the purpose of establishing a lobby in Washington and making other expenditures. It was pointed out by the officers of the Association that such action would change the status of the Association as a not-for-profit corporation.

It was stated editorially in the A. M. A. Journal, July 2: "Contrary to the expectations of agitators who endeavored to incite disharmony and revolt among the physicians who represent the medical profession in the House of Delegates, the House displayed a singleness of purpose and soundness of attitude in its concern with the important questions which came before it. The fundamental principles adopted at Cleveland were reiterated as basic to a high quality of medical service. The importance of economic factors in a solution of the health problem was emphasized. The importance of education of the public, using all the available means for reaching great numbers of people, was again recognized and the work of the headquarters office toward that end was unanimously approved."

The delegates from the Florida Medical Association will make their official reports at a meeting of the Executive Committee and these reports, when approved by that body, will be published in an early issue of the Florida Medical Journal.

The following officers were elected: President-elect, Dr. Rock Sleyster, Wisconsin; Vice-President, Dr. Howard Morrow, California; Secretary, Dr. Olin West, Chicago; Speaker of the House, Dr. H. H. Shoulders, Tennessee; Vice Speaker, Dr. Roy W. Fouts, Nebraska. Dr. Irvin Abell of Kentucky, assumed his duties as president of the Association for 1938-39.



The doctors from Florida who attended this meeting were as follows:

Baltzell, N. A.	Marianna
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Black, Nelson M.	Miami
Bryans, Herbert L.	Pensacola
Collins, C. J.	Orlando
Gurganious, Allen P.	Palatka
Halton, Joseph	Sarasota
Harris, Robert M.	Miami
Jones, Walter C., Jr.	Miami
Krueger, F. W.	Jacksonville
Limbaugh, Louie M.	Jacksonville
Lynn, C. W.	Orlando
McPhaul, W. A.	Jacksonville
Mallory, Meredith	Orlando
Murphy, C. H.	Bartow
Nichol, E. Sterling	Miami
Oetjen, Frederick	Jacksonville
Panettiere, Cayetano	Miami Beach
Pittman, J. H.	West Palm Beach
Quillian, Warren W.	Coral Gables
Sory, Bailey B., Jr.	Palm Beach
Taylor, H. Marshall	Jacksonville
Veal, E. W.	Jacksonville
Webb, C. C.	Pensacola
White, H. E.	St. Augustine

## WHERE THE DOCTORS DO STAND

### *The Milwaukee Journal*

The American Medical Association is being hammered over the head editorially in some newspapers because it did not go pell-mell for state or socialized medicine in its San Francisco convention. The inference is that of a standpat organization made up of members insensible to the public need, and intent only on fee collecting.

This kind of comment makes it all the more necessary to understand where the association drew its lines, what it did and what it refused to do.

The association did not oppose a wider use of medical care. It recognized the need for a wider use and urged its realization.

The association did not dodge the problem of caring for the indigent and the border-line cases. It urged on state and county medical societies that they develop "the most accurate and complete information that will enable them . . . maintain continuously medical care that is sufficient in amount and satisfactory in quality."

The association did not oppose group hospital insurance. It backs group hospital insurance, with proper safeguards to patient and doctor.

The association did refuse to throw the doors wide open to state medicine by indorsing some vague plan that would make the care of indigent and borderline cases, and the whole development of medicine, a burden on public treasuries, to be met by the dictatorship of bureaucracy over medical practice. If that be reaction, this country ought to be thankful for it.

What would happen if the medical men went the whole way with those advocates of state medicine who go out from Washington to make speeches at every medical convention, those doctors who are in revolt because the association will not accept European models, and those foundations with money to spend that are trying their best to fasten socialized practice on this country?

Exactly the same incompetency in regard to medical care that Harry Hopkins seems to have fastened on this country in regard to food, clothing and work—a permanent class, ever growing larger, to be provided for by the government. Do we want that? Do we want another such mistake in methods?

The association wants to keep the job within the medical profession and it thinks the state and local societies are the ones to do it. And it can be done that way. It is being done in Milwaukee County. Free care under medical decision for the truly indigent and budgeting for the borderline cases—that is, borderline cases pay what they are able to pay and no more—this plan is working out in our own area. Recent surveys have not disclosed one case of need that was not met.

Isn't that the better way? We let the doctor say whether a man is ill and needs help. The other plan would let a layman bureaucrat make the decision. Then you would have incompetency and politics mixed in, and outright graft, as they have in every European system.

This, it would seem, is the dividing line between the medical organizations and the advocates of socialized medicine.

These two selections appear on page 175 of the July 9 Journal of the American Medical Association. Members of our Association who are not Fellows of the A. M. A. are urged to borrow a copy of the July 9 A. M. A. Journal and read the other editorial comments from a selection of leading city publications.

## NEWSPAPER EDITORIAL COMMENT

Each year the annual session of the American Medical Association stimulates numerous editorial comments in the newspapers. Following is a selection of two leading city publications:

### HONEST MEN SPEAK WITH FRANKNESS AND SINCERITY

#### *San Francisco Chronicle*

The proceedings of the American Medical Association convention in San Francisco disclosed that the profession is in better health than might have been supposed from what some outside diagnosticians have said about it.

There has been and doubtless will continue to be lay criticism of some factors in the practice of medicine, extravagant claims and restrictions under extreme ethical codes. But what the lay critics have had to say upon such subjects seems almost flattering by comparison with what the medical speakers said before the convention gatherings.

These men were doctors, speaking to doctors. They lashed their fellow practitioners and themselves no less for offenses which, reduced to essentials, mean little more than that the doctors are not superhuman.

Frankly and with admirable sincerity they discussed problems of their profession, deficiencies in the sum of medical knowledge, the pursuits of vain hopes that experience has proved to be vain. And as they spoke their fellow physicians listened with respect and attention.

It was a demonstration of honesty and high purpose that would be difficult to any except a gathering of medical men. Such self accusations from a political convention or a gathering of almost any other vocational or avocational group would be unthinkable. Yet the reporters covering these meetings heard men of high professional standing discuss openly, and without imposing any seal of confidence, subjects which would put any other group on the defensive.

When men dedicated to so lofty a duty come down off the pedestal to speak as frankly and sincerely as did the doctors at the convention, they justify the confidence that millions place in them. They disclose that their professional activity is vigorous and determined to



FLORIDA SECTION, SOUTHEASTERN  
SURGICAL CONGRESS

The Florida Section of the Southeastern Surgical Congress is extending a cordial invitation to all members of the State Associations of Florida, Alabama, and Georgia to attend its Fifth Annual Clinical Conference to be held at the Florida State Hospital, Chattahoochee, Florida, on Saturday, August 27.

The meeting will convene at 9 A. M. Lunch will be served through the courtesy of the Hospital at 1 P. M., and the meeting will adjourn at 4 P. M.

There are no set papers at these meetings. Clinical cases will be presented and discussed by the invited speakers, followed by open discussion from the floor.

The previous conferences held by this group have proved most valuable and interesting, and it is expected that there will be a large attendance at this meeting.

The program is as follows:

## PROGRAM

DR. J. S. TURBERVILLE, Presiding

1. 9:00 A.M. "Surgical Lesions of the Right Lower Quadrant Simulating Acute Appendicitis"

DR. W. R. MEEKER, Mobile

2. 9:40 A.M. "Cervicitis"

DR. WALTER HOLMES, Atlanta

3. 10:20 A.M. "Acute Pelvic Conditions Before and After Treatment"

DR. WALTER JONES, Miami

*11 A. M.—Ten Minutes Intermission*

4. 11:10 A.M. "Clinical Examination of Surgical Patients"

DR. T. C. DAVISON, Atlanta  
*President S. E. S. Congress*

5. 11:50 A.M. "Clinical Examination in Cases of Nutritional Disturbances"

DR. JAMES MCLESTER, SR., Birmingham  
*Past President Am. Med. Assoc.*

*1 P. M.—Lunch*

(Courtesy Florida State Hospital)

Informal Talks

DR. B. T. BEASLEY, *Sec'y S. E. S. C.*  
MR. J. H. THERRELL, *Supt.*

Florida State Hospital

6. 2:30 P.M. "Operative Treatment of Involutional Insanity of Agitational Type"

DR. J. G. LYERLY, Jacksonville

7. 3:00 P.M. "Roentgen Ray in Diagnosis of Some Surgical Brain Diseases"

DR. W. McL. SHAW, Jacksonville  
(Papers of Drs. Lyerly and Shaw to be discussed together)

8. 3:30 P.M. "Medical Aspects of Gall Bladder Disease"

DR. FRED WILKERSON, Montgomery

*Committee*

DR. FRANK D. GRAY DR. ED. JELKS  
DR. WALTER JONES DR. J. C. DAVIS  
DR. J. S. TURBERVILLE, *Chairman*

## MEDICAL DISTRICT MEETING—A

Panama City, July 14

The second annual meeting in the Northwest Medical District was held at Panama City, Thursday afternoon at three o'clock, with headquarters at the St. Andrews Yacht Club. This is a very fine district and the doctors are extremely enthusiastic. The meeting was a great success from every angle and those who attended will really be able to appreciate the importance of the occasion. It is hoped that the reports carried home to the various parts of the district will create added interest and that at the next annual meeting an even larger attendance may be had. There was a total registration of 95. Of this number, 51 were Association members (from this district, 49); 15 were visitors; and 29 were ladies.

A boat was chartered for the afternoon as part of the entertainment for the ladies and their guests. The cruise on the beautiful St. Andrews Bay, which extended out into the Gulf of Mexico, delighted those who were there to enjoy this part of the program. In the evening a buffet supper was served in the lounge of the Yacht Club and on the terrace. It was a most delightful occasion. After supper, the group returned to the assembly room, where Dr. Herbert L. Bryans showed on the screen a moving picture of the annual meeting in St. Petersburg and the last annual meeting of the Northwest Medical District, which was held in Apalachicola. As this reel progressed, Doctor Bryans commented on the individual pictures as they appeared and explained many of the scenes. This contribution by Doctor Bryans was one of the important features of the meeting. The pictures of doctors in the audience appeared on the screen and it was evident that many of them had not known their pictures were being taken. Throughout this meeting, Doctor Bryans was busy with his moving picture camera and announced that those who were desirous of seeing themselves in the movies should by all means attend the next annual meeting of the district in Marianna.

Dr. J. C. O'Gwynn of Mobile, Alabama, then gave a very interesting lecture on his travels through India, Japan and China. Doctor O'Gwynn traveled 33,000 miles in for-

eight countries and spent eleven months on his last trip. Following the lecture, Doctor O'Gwynn showed an interesting moving picture which was enthusiastically received by his audience.

At 3 p. m. Dr. N. A. Baltzell, President of the Northwest District, called the meeting to order. In the absence of Dr. W. J. Blackshear, President of the Bay County Medical Society, Dr. W. C. Roberts gave the address of welcome. The presiding officer then called on Dr. W. Henry Spiers, President of the State Association, and Doctor Spiers in his address, outlined the Association's program for the year and presented a proposed Medical Practice bill for the members to study. Telegrams were read by Doctor Baltzell from Dr. Shaler Richardson, Dr. Harrison A. Walker and Dr. Leigh F. Robinson, advising that, owing to unavoidable circumstances, they were unable to attend the meeting. Four past presidents were then called upon: Dr. Henry E. Palmer, Dr. F. Clifton Moor, Dr. Julius C. Davis and Dr. Herbert L. Bryans. These past presidents each had a special message and were enthusiastically applauded. Doctor Bryans had just returned as a delegate from Florida to the A. M. A. meeting in California and gave a brief outline of that meeting.

Dr. Gilbert S. Osincup, Chairman of the Executive Committee, was then recognized and he urged the officers of the component societies to check their files to see that they had adequate constitutions and by-laws for their societies. Doctor Osincup advised that a model would be supplied by the Association office to any society that did not have a constitution and by-laws and emphasized the importance of every county medical society having a properly worded constitution and by-laws officially adopted and in force. He then outlined the importance of a minimum fee schedule and requested every doctor present who had not received his copy which was mailed from the State Association's office on June 2, 1938, to secure it from his secretary as soon as possible. Mimeographed copies of the minimum fee schedule, together with a covering letter from Doctor Osincup, were mailed to the secretary of every county medical society. Enough copies were furnished to the secretary for each member of his society.

Doctor Baltzell then announced that the next order of business would be the selection of a meeting place for 1939. Dr. D. A. McKinnon, President of the Jackson County Medical Society, extended an invitation to meet in Marianna in 1939. On motion made, seconded and carried, Marianna was unanimously selected.

At 4:30 the gavel was turned over to Dr. C. C. Webb, President-elect, who presided at the scientific session. Four very interesting scientific papers were read as follows: "Black Widow Spider Bite" by Dr. T. W. Griffin, Quincy; "Chronic Maxillary Sinusitis Associated With Dental Caries" by Dr. J. N. McLane, Pensacola; "Acute Empyema Thoracotomy" by Dr. C. D. Whitaker, Marianna; and "Obstetrical Oddities Occurring in a Single Patient" by Dr. W. C. Roberts, Panama City. The program adhered to the time schedule which had been set. This was made possible largely through the foresight of Doctor Baltzell who called the meeting to order promptly at 3 p. m. There was ample time for the discussion of scientific papers and Doctor Webb, the presiding officer, allowed a full discussion on each paper as it was read. A great many of the doctors present took part in these discussions which added greatly to the value of the papers. Every essayist scheduled on the program for a paper was present and a hearty vote of thanks was extended to them for their contribution to the meeting. A vote of thanks was extended also to Dr. W. C. Roberts and the members of his local committee on arrangements. Mrs. D. M. Adams and her assistants were extended a vote of appreciation for the splendid entertainment of the doctors' wives and their guests. The officials of the St. Andrews Yacht Club were praised for the many courtesies extended and for allowing the use of their facilities for this second annual meeting in the Northwest District.

#### REGISTRATION

Baltzell, N. A., <i>President</i> .....	Marianna
Webb, Carol C., <i>President-elect</i> .....	Pensacola
Thompson, Stewart, <i>Managing Director</i> .....	Jacksonville

#### Association Members

Adams, D. M.....	Panama City
Ball, W. H.....	Apalachicola
Britt, Otis W.....	Chattahoochee
Brown, G. W.....	Tallahassee
Bryans, Herbert L.....	Pensacola
Carter, George W.....	Chipley
Conter, August E.....	Apalachicola
Dalton, B. W.....	Vernon
Davis, Julius C.....	Quincy

Fisher, L. C.	Pensacola	Pound, Mrs. J. H.	Tallahassee
Fraser, Donald S.	Panama City	Sapp, Mrs. J. W.	Havana
Gainey, J. G.	Blountstown	Segrest, Mrs. R. H.	Bonifay
Garmony, G. H.	Havana	Statham, Mrs. J. C.	Chattahoochee
Griffin, Taylor W.	Quincy	Thames, Miss Christine	Milton
Hixon, W. P.	Pensacola	Veverka, Mrs. R. D.	Panama City
Hoffman, James M.	Pensacola	Watson, Mrs. F. M.	Chipley
Holland, Francis T.	Tallahassee		
Johnston, J. K.	Tallahassee		
Kennedy, Robert L.	Malone		
Lischkoff, M. A.	Pensacola		
Lisenby, A. H.	Panama City		
McKinnon, D. A.	Marianna		
McLane, J. N.	Pensacola		
Middlebrooks, W. E.	Panama City		
Miles, W. G.	Chattahoochee		
Miller, Allen H.	Millville		
Miller, R. L.	Graceville		
Moor, F. Clifton	Tallahassee		
Nixon, J. M.	Panama City		
Nobles, Robert G.	Pensacola		
Osincup, G. S.	Orlando		
Palmer, Henry E.	Tallahassee		
Paul, L. H.	Bonifay		
Perkins, Herman	Panama City		
Pierce, J. L.	Marianna		
Pound, J. H.	Tallahassee		
Quina, M. E.	Pensacola		
Roberts, W. C.	Panama City		
Robertson, J. C.	Chattahoochee		
Rogers, W. D.	Chattahoochee		
Sapp, J. W.	Havana		
Segrest, R. H.	Bonifay		
Smith, H. D.	Panama City		
Spiers, W. H.	Orlando		
Stevens, Ralph E.	Chattahoochee		
Turberville, J. S.	Century		
Watson, F. M.	Chipley		
Whitaker, C. D.	Marianna		
Whitfield, J. M.	Panama City		
Wilkinson, B. A.	Tallahassee		

*Visitors*

Allen, Dr. J. W.	Dothan, Ala.
Daves, Dr. F. E.	Chattahoochee
Gignac, Dr. Ralph M.	Detroit, Mich.
Hester, Henry	Ft. Benning, Ga.
Kennedy, Robert	Malone
Kennedy, William	Malone
Latiolais, Dr. S. G.	Dothan, Ala.
Lingo, Dr. M. J.	Panama City
Parish, Theodore D.	Vernon
Roberts, Dr. W. C., Sr.	Dothan, Ala.
Statham, Dr. J. C.	Chattahoochee
Tiller, Dr. O. B.	Chipley
Ward, Dr. A. L.	Port St. Joe

*Woman's Auxiliary—Members and Guests*

Adams, Mrs. D. M.	Panama City
Baltzell, Mrs. N. A.	Marianna
Bowen, Mary L.	Tallahassee
Britt, Mrs. O. W.	Chattahoochee
Conner, Julette	Milton
Fisher, Mrs. L. C., Jr.	Pensacola
Garmony, Mrs. G. H.	Havana
Griffin, Mrs. T. W.	Quincy
Hester, Mrs. Henry	Ft. Benning, Ga.
Holland, Mrs. F. T.	Tallahassee
Hooks, Ema	Shreveport, La.
Kennedy, Mrs. R. L.	Malone
Kennedy, Evelyn	Malone
Kennedy, Margaret	Malone
Krentzman, Miss Sara M.	Milton
Lingo, Mrs. M. J.	Panama City
Lischkoff, Mrs. M. A.	Pensacola
Lischkoff, Blanche	Pensacola
Lischkoff, Marion	Pensacola
Moor, Mrs. F. C.	Tallahassee
Nixon, Mrs. J. M.	Panama City
Pierce, Mrs. J. L.	Marianna

## INVITATION—ORLANDO PICNIC

All members of the Florida Medical Association are cordially invited to attend the annual picnic and barbecue of the Orange County Medical Society. This annual affair will be held at Clyde McKinney's Camp, located five miles south of Orlando on the Dixie Highway, just north of Lakeside Park. The date is Thursday afternoon, September 1. For many years this annual picnic and barbecue has been a very happy occasion for the doctors of organized medicine. The local society has an enviable reputation for staging a picnic and barbecue and has issued this invitation to all members of the State Association, urging them to be present and meet their colleagues.

## STATE NEWS ITEMS

The secretary of the Florida Medical Association would like to secure the following records to complete the files in the Association's office:

Journal of the Florida Medical Association for June, 1915, and May, 1916.

Index Medicus, volume 9, 1924.

American Medical Directory for 1907, 1923, 1925, 1927 and 1931.

\* \* \*

Dr. Lauren Sompayrac of Jacksonville left on July 1 for New York, where he will take special courses in dermatology at New York Postgraduate Medical School. He will return to Jacksonville in the fall to resume his practice.

\* \* \*

Dr. J. Harris Pierpont of Pensacola recently returned from attending surgical clinics at several of the New York hospitals.

\* \* \*

Dr. Maximilian Stern of Daytona Beach left on July 9 for his summer home in the Thousand Islands. Before returning, October 15, he will visit the hospitals in New York, with which he is still associated.



Dr. R. Sam Mosley of Miami and Miss Elizabeth Stuckey of Pahokee were married July 10 in the First Methodist Church at Asheville, N. C. Their honeymoon was spent in New York City and Bermuda.

\* \* \*

The Rosenblum Trophy, awarded to the winner of the annual skeet shoot of the Jacksonville Gun Club was won by Dr. J. W. Hayes, who shot a perfect score of 100 out of 100 recently.

\* \* \*

Dr. Lloyd J. Netto of West Palm Beach spent the week of June 27 in Nashville attending surgical clinics at Vanderbilt University and St. Thomas Hospital.

\* \* \*

Dr. J. M. Willis of Williston was re-elected on July 12 in the annual city election as mayor. His whole administration ticket won by about a 3 to 1 majority.

\* \* \*

Dr. and Mrs. Louis M. Orr, II, of Orlando sailed from New York on the S.S. Reliance for a six weeks' North Cape cruise.

\* \* \*

Dr. Charles E. Boynton, Jr., formerly of West Palm Beach, has become associated in practice with his father. Doctors Boynton announce the opening of offices at 906 Doctors Building, Atlanta.

\* \* \*

Dr. C. A. Scarborough of Miami announces the removal of his offices from 800 N. E. Second Avenue to 655 N. W. 62nd Street.

\* \* \*

Dr. George H. Day has announced his removal from Miami to Sarasota.

\* \* \*

Dr. George O. Davis of Madison died at his home on July 6, of coronary thrombosis, at the age of 62.

\* \* \*

Dr. and Mrs. J. R. McEachern of Tampa were guests in July of Dr. and Mrs. T. S. Roberts at Atlantic Beach.

\* \* \*

Dr. and Mrs. Gordon H. Ira of Jacksonville attended the annual meeting of the Chattahoochee Valley Medical Association in Albany, Georgia, the middle of July.

Dr. and Mrs. E. Clay Shaw of Miami spent a three weeks' vacation in July at the Chateau Frontenac, Quebec, Canada. Doctor Shaw attended the American Urological Convention while there.

\* \* \*

Dr. Lauren M. Sompayrac of Jacksonville was recently honored by the local Junior Chamber of Commerce with the award of the Robert L. Schirmer cup in recognition of his "meritorious leadership" during the past six months. Doctor Sompayrac received the honor because of his work as chairman of the health and sanitation committee which has done much to focus public attention upon the national campaign to combat the spread of syphilis and other venereal diseases.

\* \* \*

Dr. Alfred G. Levin of Miami recently took special work at Memorial Hospital in New York City for the treatment of cancer and allied diseases.

\* \* \*

Dr. Joseph Rose of Jacksonville left last month for postgraduate work in the North.

\* \* \*

Dr. and Mrs. C. H. Murphy of Bartow returned last month from a 7,000-mile motor trip to California. After attending the A. M. A. meeting, they were present also at the Rotary International in San Francisco.

\* \* \*

Dr. Joseph Halton of Sarasota left the first of August for Chicago where he is taking a two weeks' course in gastric surgery. Doctor Halton plans to visit the Crile Clinic in Cleveland and will spend the month of September studying cancer at the Memorial Hospital in New York.

\* \* \*

Sympathy is extended to Dr. M. Jay Flipse in the recent death of his father.

\* \* \*

Dr. B. L. Whitten of Miami is on an extended cruise during which he will visit Hawaii, the South Sea Islands and Australia. He expects to return in September.

\* \* \*

Dr. Scheffel Wright of Miami recently spent a two weeks' vacation with his brother in Beverly Hills, California.

Dr. and Mrs. Bascom Palmer of Miami have returned from the mountains in North Carolina after visiting their daughters at Rockbrook Camp. Doctor Palmer also made a brief trip to San Antonio, Texas, where he attended the School of Aviation Medicine at Randolph Field.

\* \* \*

The 23rd annual meeting of the American Association of Railway Surgeons will be held at the Palmer House, Chicago, September 19-23, 1938. An extremely interesting and highly profitable program has been arranged and all physicians and surgeons are invited to attend the sessions of this meeting as guests of the organization. There will be no registration fee to M. D. non-member guests. A cordial invitation for you to attend is extended by Dr. Harvey Bartle, President of the Association. Complete program and information regarding the meeting and the exhibits may be secured by addressing Mr. A. G. Park, Convention Manager, the American Association of Railway Surgeons, Palmer House, Chicago.

\* \* \*

Dr. and Mrs. S. A. Morris of Jacksonville sailed from San Francisco on July 19 for Australia and the East Indies. They expect to return home about September 15.

\* \* \*

Dr. and Mrs. W. C. Williams, Jr., and son, W. C. Williams, III, of West Palm Beach, recently returned from several weeks' vacation. Doctor Williams attended urological clinics in Chicago and at Mayo Hospital in Rochester, Minn.

\* \* \*

Dr. O. E. Harrell of Jacksonville was guest speaker of the Duval County Federation of Women's Clubs in a health program broadcast over WJAX, Wednesday evening, July 27. Doctor Harrell spoke on the eradication of venereal disease.

\* \* \*

Drs. J. G. Lyerly and W. McL. Shaw of Jacksonville were recent visitors at the Florida State Hospital in Chattahoochee where they attended the regular monthly staff conference.

\* \* \*

Dr. and Mrs. Aaron Z. Oberdorfer of Jacksonville recently returned from a two-weeks' motor trip to New Orleans and Atlanta where Doctor Oberdorfer visited hospitals and clinics.

Dr. and Mrs. M. A. Kugel of Miami Beach are spending the summer in Maine. Before returning, Doctor Kugel will visit clinics in New York, Philadelphia, and Baltimore.

\* \* \*

The many friends of Dr. Henry Hanson will be pleased to learn that he expects to be in Florida the early part of November this year. Doctor Hanson is located in Guayaquil, Ecuador, and expects to fly to the U. S. A. for a hurried trip.

\* \* \*

Dr. Robert Y. H. Thomas of Jacksonville returned last month from a motor trip to points of interest in Texas, Louisiana, Alabama and Mississippi.

\* \* \*

Dr. John E. Burch of Miami announces the opening of offices for the practice of medicine and surgery at 600 West Flagler Street.

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**PHYSICIAN WANTED:** Office equipment and drugs for sale, owing to the death of a physician who has practiced in the location for more than 40 years. Write H. Gattrell, Jr., Fairfield (Marion County), Florida.

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## COMPONENT COUNTY SOCIETIES

### DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society held its regular meeting on the evening of August 2 at the Ingraham Building. Dr. James H. Putman of Miami read a paper on "Pain in the Right Hypochondrium, Some Factors in its Production," which was discussed by Drs. P. B. Welch and J. W. Snyder.

\* \* \*

### DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

Dr. L. W. Martin was host on July 12 to the members of the DeSoto-Hardee-Highlands County Medical Society, when he entertained fifteen doctors. The meeting opened with a dinner served in the recreation room of the new Sebring General Hospital. Dr. A. A. Poucher of Wauchula was the essayist of the evening, and spoke on "Symbiosis," which was followed by a general discussion. The guests were then conducted on a tour of the building and shown the newly installed equipment.

MONROE COUNTY MEDICAL SOCIETY

THE MONROE COUNTY MEDICAL SOCIETY, SMALLEST SOCIETY OF THE ASSOCIATION, AGAIN IS ON THE HONOR ROLL. YEAR AFTER YEAR THIS SOCIETY PAYS ITS ASSESSMENT IN FULL. DR. HARRY C. GALEY IS PRESIDENT AND DR. WILLIAM R. WARREN IS SECRETARY-TREASURER.

\* \* \*

PINELLAS COUNTY MEDICAL SOCIETY

THE PINELLAS COUNTY MEDICAL SOCIETY HAS JOINED THE HONOR ROLL OF 100% PAID SOCIETIES FOR 1938. THIS SOCIETY, WHICH HAS A MEMBERSHIP OF 86 ACTIVE AND 4 HONORARY MEMBERS, IS HEADED BY DR. J. A. STRICKLAND, PRESIDENT; DR. E. C. MacCORDY, PRESIDENT-ELECT; DR. J. A. HERRING, FIRST VICE-PRESIDENT; DR. F. H. LANGLEY, SECOND VICE-PRESIDENT; AND DR. W. C. McCONNELL, SECRETARY-TREASURER. OF THE SOCIETIES HAVING A MEMBERSHIP OF 50 OR MORE, PINELLAS COUNTY SOCIETY WAS THE FIRST TO BECOME 100% PAID IN 1936 AND 1937. IT IS THE SECOND LARGE SOCIETY ON THE PAID-UP LIST IN 1938, BEING PRECEDED ONLY BY ORANGE COUNTY MEDICAL SOCIETY.

\* \* \*

PUTNAM COUNTY MEDICAL SOCIETY

THE PUTNAM COUNTY MEDICAL SOCIETY IS 100% PAID FOR 1938. THIS SOCIETY, WITH A SCATTERED MEMBERSHIP OF 10, HAS AS ITS PRESIDENT THIS YEAR DR. Z. BRANTLEY OF GRANDIN. DR. ALLEN P. GURGANIOUS IS SERVING AS SECRETARY AND TREASURER. CONGRATULATIONS, PUTNAM COUNTY MEDICAL SOCIETY.

MEDICAL DISTRICT MEETINGS

Ponte Vedra (C).....September 15, 1938  
Bradenton (D).....September 29, 1938  
Ft. Lauderdale (F).....October 13, 1938  
Gainesville (B).....October 27, 1938  
Eustis (E).....November 10, 1938

ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

Studies on Oxyuriasis, II. A Preliminary Note On Treatment with Tetrachlorethylene,—WRIGHT, WILLARD H.; BOZICEVICH, JOHN, Washington, D. C., and ROSE, JOSEPH, Washington, D. C. (now of Jacksonville). *Virginia M. Monthly* 64:339-341 (Sept.), 1937.

Preliminary statistics are presented by the authors concerning the treatment of 11 cases of pin worm infestation with tetrachlorethylene. Six of the eleven cases were persistently negative for Oxyuris ova as checked by the Hall cellophane swab method of examination.

The regimen of treatment was as follows: A light, fat-free supper was given the night before treatment. An enema was administered at 9 p.m. No breakfast was allowed the following morning. The anthelmintic was administered in magnesium sulphate or citrate at 7 a. m.

The dosage of the drug was estimated at .1 cc. per year of apparent age up to 12 years and thereafter according to the weight, age, and physical condition of the patient.

Tertiary Prostatic Hypertrophy—An Unusual Case Report—UHLE, CHARLES A. W., Philadelphia; and MELVIN, PERRY D., Miami. *J. Urol.* 38:487-493 (Nov.), 1937.

The author presents a case of recurrent prostatic hypertrophy and discusses the surgical pathology involved in prostatic hypertrophy and recurrence.

The patient underwent the first operation December 2, 1925 at the age of 61. Five years later he returned because of a suprapubic sinus. At this time the prostate was normal in size and consistency. In March, 1932, he again returned because of a suprapubic fistula. Rectal examination revealed a grade 3 prostatic enlargement. A large lateral lobe and smaller posterior commissure were enucleated. The patient was again admitted 3 years later and grade 1 enlargement of the left lobe and grade 2 of the right were found. At this time 5 grams of hypertrophied pros-



tate were removed by transurethral resection. Since that time the fistula has remained closed and the patient is free of complaints.

**The Technique of Appendectomy—OCHSNER, ALTON, New Orleans; and LILLY, GEORGE, Miami, *Surgery* 2:532-554 (Oct.), 1937.**

Three methods of appendectomy are in use at the present time, all of which have had certain drawbacks: simple ligation; ligation and inversion; and inversion without ligation.

With the first method there is danger of inadequate closure because serosa is not in apposition with serosa. The ligated infected stump lies free in the peritoneal cavity and may be an active source of contamination as well as a favorable point for the formation of adhesions. There is also the very grave danger of slipping of the ligature with consequent outpouring of fecal contents into the peritoneal cavity.

The main danger of the ligation and inversion method is the development within the wall of the cecum of an abscess due to complete enclosure of the infected stump in a pocket produced by the purse-string suture. This abscess may rupture into the peritoneal cavity although the rupture is probably usually into the lumen of the bowel. Even though an abscess may not form there is probably always an inflammatory reaction at this point with the added danger of peritoneal adhesions and later intestinal obstruction.

Inversion without ligation, the method favored by the authors, presents several disadvantages that are apparently obviated by a technique they have used for many years. The stump may open and cause contamination before it has been inverted and hemorrhage may occur from an intramural artery in the stump of the appendix. The first danger is overcome by the application of three Ochsner clamps to the base of the appendix with severance between the middle and distal clamp. The middle clamp is then removed, the stump is grasped firmly with tissue forceps and is then quickly inverted after the removal of the proximal clamp. Hemorrhage from an intramural artery is obviated by taking a complete loop within the purse string suture at the point of mesenteric attachment, thereby securing any artery of this type.

**Gastroscopic Studies—GAITHER, ERNEST H., Baltimore; and BORLAND, JAMES L., Jacksonsville, *J.A.M.A.* 110:436-439 (Feb. 5), 1938.**

This is a summary of impressions gained from a large number of careful gastroscopic studies. Due to insufficient correlation between pathology and gastroscopic findings, the criteria by which disease entities are to be invariably recognized in the stomach are not as yet established.

Gastritis can be divided into superficial, hypertrophic and atrophic types according to the gastroscopic picture. Most gastritis cases show activity, that is, inflammation, hypertrophy, ulceration, hemorrhage, edema or localized injection. Almost all gastroenterostomies show evidences of inflammation even years after operation. In the atrophic types the mucosa is thinned, unhealthy, the rugae flattened out, and a network of blue veins is noticeable. Atrophy is especially noted in pernicious anemia and frequently tends to be localized in one of the six "zones" of the stomach, such zones having been described in previous communications.

#### ERRATUM

In this department of the May, 1938, Journal appeared an abstract of Dr. Paul T. Butler's article on "Injection Treatment of Hernia." In the abstract the statement was made that the usual number of injections was from five to ten. We wish to correct this mistake. Nowhere in the article did Doctor Butler make this statement.

#### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**MEDICAL WRITING.** By MORRIS FISHBEIN, M. D., Editor The Journal of the American Medical Association, Chicago. This volume constitutes an extensive revision of a previous work by Simmons & Fishbein, "The Art and Practice of Medical Writing", with the addition of much new material. An introductory "Note", defines the purpose of the book: "With a view to assisting in the literary improvement of papers accepted for publication in its periodicals, the American Medical Association Press has adopted certain rules of style. Many of these rules of style are incorporated in this book, with the hope that they will be helpful to authors in the preparation of their articles." Among the many topics covered are: "An Acceptable Paper", "Style", "Construction of the Manuscript", "Words and Phrases", "Bibliographic Material", "Preparation of the Manuscript", "Illustrations". Cloth. Pp. 212, with illustrations. Chicago: Press of American Medical Association, 535 N. Dearborn St.



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## ADVERTISERS' NOTES

A NEW PORTABLE MODEL  
ELECTROCARDIOGRAPH OF  
INTERESTING CHARACTERISTICS

The Cambridge Instrument Company, Inc., through its Florida sales and service representatives—the Keleket X-Ray Company of Florida, announces a new model portable electrocardiograph, incorporating interesting features. The new model is known as the "Simpli-Trol" Portable model Hindle Electrocardiograph. As the name implies, simplicity of control is the keynote of the new design, all necessary functions being performed with a minimum of operations. The entire panel itself has only three control knobs.

The entire equipment, including electrodes and accessories, is housed in a single mahogany carrying case 8" wide, 10" high and 19" long, weighing 30 pounds complete. According to the manufacturer, the improved simplicity and compactness have been gained without compromising important fundamentals, accuracy of record or completeness of instrument functions.

The new model employs no storage batteries, the current required for its operation being taken from the house lighting circuit. Time marking of tracings is independent of the camera driving motor and is accomplished by a rotating time-wheel driven by a synchronous electric motor of self-starting and self-synchronizing type.

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The rugged, but highly sensitive Einthoven String Galvanometer records heart action currents directly, without external amplification. This results in accuracy, simplicity and minimum of external disturbances.

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#### PARKE, DAVIS & COMPANY ELECTS NEW PRESIDENT AND NEW FINANCE CHAIRMAN

Dr. A. William Lescohier was elected President of Parke, Davis & Company, and Norman H. F. McLeod Chairman of the Finance Committee, at a meeting of the Company's Board of Directors held in Detroit on March 1. Both men have been actively connected with the Company for about thirty years. Dr. Lescohier has been General Manager and a Director since 1929, and Mr. McLeod a member of the Board since 1921, and Secretary and Treasurer since 1923.

Dr. Lescohier succeeds Oscar W. Smith,



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who had been President of the Company for sixteen years until his death on February 7 of this year. Dr. Lescohier was born in Detroit, a few blocks from the laboratories of which he now becomes the chief executive. After graduating from high school he worked a year or two in the laboratories and then entered Detroit College of Medicine. In 1909, following his graduation from college, he became a member of the Parke-Davis Research Staff, giving special attention to biological problems. In 1918 he was named Assistant Director of the Research and Biological Laboratories, in which capacity he was in charge of the production of serums, vaccines, antitoxins, and other biological products. In 1925 he was made Director of the Department of Experimental Medicine, and in 1928 he was appointed to the position of Assistant-to-President. In 1929 he was elected General Manager, which position he has occupied since that time.

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Florida Medical Association	W. Henry Spiers, Orlando	Shaler Richardson, Jacksonville	Daytona Beach, 1939
Florida Medical Districts:			
A—Northwest	N. A. Baltzell, Marianna	Stewart Thompson, Jacksonville	Marianna, 1939
B—North Central	R. B. Harkness, Lake City	" " "	Gainesville, Oct. 27, 1938
C—Northeast	W. McL. Shaw, Jacksonville	" " "	Ponte Vedra, Sept. 15, 1938
D—Southwest	J. W. Alsobrook, Plant City	" " "	Bradenton, Sept. 29, 1938
E—South Central	H. D. Clark, Ft. Pierce	" " "	Eustis, Nov. 10, 1938
F—Southeast	H. A. Walker, Miami Beach	" " "	Ft. Lauderdale, Oct. 13, 1938
Alabama Medical Association	Seale Harris, Montgomery	D. L. Cannon, Montgomery	Montgomery, Apr. 18-20, 1939
Georgia Medical Association	Grady N. Coker, Canton	E. D. Shanks, Atlanta	Atlanta, May 9-12, 1939
Florida—			
State Dental Association	R. D. Cummins, St. Petersburg	Lloyd Harlow, Bradenton	Jacksonville, Nov. 10-12, 1938
Soc. of Derm. and Syph.	C. A. Andrews, Tampa	Lauren Sompayrac, Jacksonville	Daytona Beach, 1939
East Coast Medical Association	Walter C. Jones, Miami	T. C. Kenaston, Cocoa	Rockledge, Oct. 28, 29, 1938
State Hospital Association	Gertrude Overstreet, Gainesville	Mr. Fred Walker, Jacksonville	Jacksonville, Apr. 13-15, 1939
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Midland Medical Society	W. C. McConnell, St. Petersburg	B. H. Sanchez, Plant City	Sebring, Oct. 27, 1938
State Nurses Association	Mrs. Inez Nelson, Orlando	Mrs. Phyllis Leonard, St. Augustine	Sarasota, Nov. 7-9, 1938
Pediatric Society	Gilbert S. Osincup, Orlando	Warren Quillian, Coral Gables	Daytona Beach, 1939
Pharmaceutical Association	Mr. R. Q. Richards, Ft. Myers	Mr. A. W. Morrison, Miami	Hollywood Beach, May, 1939
Public Health Association	N. A. Upchurch, Jacksonville	E. M. L'Engle, Jacksonville	Hollywood, Nov. 28-30, 1938
Radiological Society	H. O. Brown, Tampa	J. H. Lucinian, Miami	Daytona Beach, 1939
Railway Surgeons Association	Herman Watson, Lakeland	H. D. Clark, Ft. Pierce	Daytona Beach, 1939
Tuberculosis & Health Assn.	Mr. G. E. Therry, W. Palm Beach	Mrs. May Pynchon, Jacksonville	Fall, 1938
Chattahoochee Valley Med. Assn.	J. S. Turberville, Century	Frank K. Boland, Atlanta	Albany, Ga., July 11-13, 1939
Gulf Coast Clinical Society	H. L. Bryans, Pensacola	J. H. Baumhauer, Mobile, Ala.	Pensacola, 1938
Southeastern Derm. Assn.	J. L. Kirby-Smith, Jacksonville	Joseph A. Elliott, Charlotte, N. C.	Charlotte, Sept. 4, 1938
Southeastern Surgical Congress	T. C. Davison, Atlanta	B. T. Beasley, Atlanta	Atlanta, Mar. 6-8, 1939
Southern Medical Association	Frank K. Boland, Atlanta	Mr. C. P. Loran, Birmingham	Oklahoma City, Nov. 15-18, 1938
Suwannee River Medical Society	E. C. Chamberlain, Madison	Eustace Long, Madison	



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While making no therapeutic claims, we offer the following references to the literature for the attention of physicians:

### REFERENCES

1. "Treatment of Human Pellagra with Nicotinic Acid"—Fouts, Helmer, Lepkovsky and Jukes: Proc. Soc. Exp. Biol. and Med.; 37: 405 (Nov.) 1937.
2. "Relation of Nicotinic Acid and Nicotinic Amide to 'Canine Black-tongue'"—Elvehjem, Madden, Strong and Wooley: Jrl. Amer. Chem. Soc. 59:1767: (Sept.) 1937.
3. "Therapeutic Administration of Nicotinic Acid in Human Beings During Health and Disease"—Spiers, Cooper and Blankenhorn. (Read before the Central Society for Clinical Research, Chicago—Nov. 1937).
4. "Nicotinic Acid and the Pellagra Preventing ('P-P') Vitamin"—Harris; Chem. & Ind.; 56:1134: (Dec.) 1937.
5. "Pellagra Successfully Treated with Nicotinic Acid—A Case Report"—Smith, D. T., M.D.; Jrl. A.M.A. 109:2054: (Dec. 18) 1937.
6. "Nicotinic Acid and Vitamin B<sub>2</sub>"—Dann, W. J.; Science, 86:616: (Dec. 31) 1937.
7. "Pellagra and Nicotinic Acid." An editorial—Jrl. A. M. A. 110: 289: (Jan. 22) 1938.
8. "Relation of Nicotinic Acid to Human Pellagra." An editorial—Jrl. A. M. A. 109:1203: 1937 (Oct. 9).
9. "The Use of Nicotinic Acid in the Treatment of Pellagra"—Spiers, Cooper and Blankenhorn; Jrl. A. M. A. 110:622:1938 (Feb. 26).
10. "Advances in the Treatment of Pellagra." An editorial, Annals of Internal Medicine, 11:1760: 1938 (March).
11. "A note on the Relationship of Porphyrinuria to Human Pellagra." by Tom Douglas Spiers, M. D.; Yasuo Sasaki, Ph. D.; and Esther Gross, M. S., Southern Medical Journal, Vol. 31, No. 5, May, 1938, page 483.

Physicians may obtain SMAco Nicotinic Acid (3: Pyridine Carboxylic Acid) for clinical use in tablet form for oral administration. Two potencies are available: 100 milligrams per tablet, or 20 milligrams per tablet.

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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Districts	COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Panama City July 14, 1938	Bay	W. J. Blackshear, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'40 Carol C. Webb, M. D., Pensacola	11	10
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		42	38
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		Santa Rosa	8	100%
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	16	13
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	Calhoun-Franklin-Gulf	38	35
North Central District (B) Gainesville, October 27, 1938	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanch Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harless, M. D., Lake City	18	15
	Madison	E. Long, M. D., Madison				4	3
	Taylor	Ralph J. Greene, M.D., Perry	W. J. Baker, M. D., Poley	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton-Lafayette-Suwannee	8	6
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M. D., McIntosh	27	22
	Marion	Carney W. Minns, M. D., Commercial Bank Bldg., Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	21
	Pasco-Hernando-Citrus	Samuel C. Harvard, M. D., Brooksville	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		14	12
N. E. District (C) Ponte Vedra Sept. 16, 1938	Sumter	Clyde L. Carter, M.D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesday	Bradford-Gilchrist-Levy-Union	5	100%
	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	161	145
	St. Johns	John J. Spencer, M.D., 32 Saragossa St., St. Augustine	Vernon A. Lockwood, M.D., East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Olay-Nassau	10	100%
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganous, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M. D., Daytona Beach	10	100%
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258 1/2 S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	39	34
	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St., Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	108	95
Southwest District (D) Bradenton, September 29, 1938	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		13	100%
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		90	100%
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		15	12
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	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stine, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	11
	Polk	W. W. Shaffer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Charlotte-Collier-Glades-Hendry	64	55
South Central District (E) Eustis, Nov. 10, 1938	Brevard	G. E. Christie, M.D., Titusville	I. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M. D., Cocoa	12	100%
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	Dade	Arthur H. Wellard, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzer, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	280	258
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Florida Medical Association, Daytona Beach, 1939  
Southern Medical Association, Oklahoma City, November 15-18, 1938

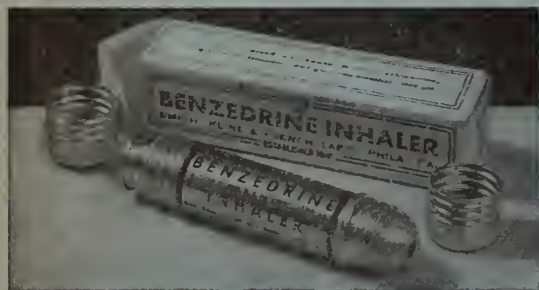
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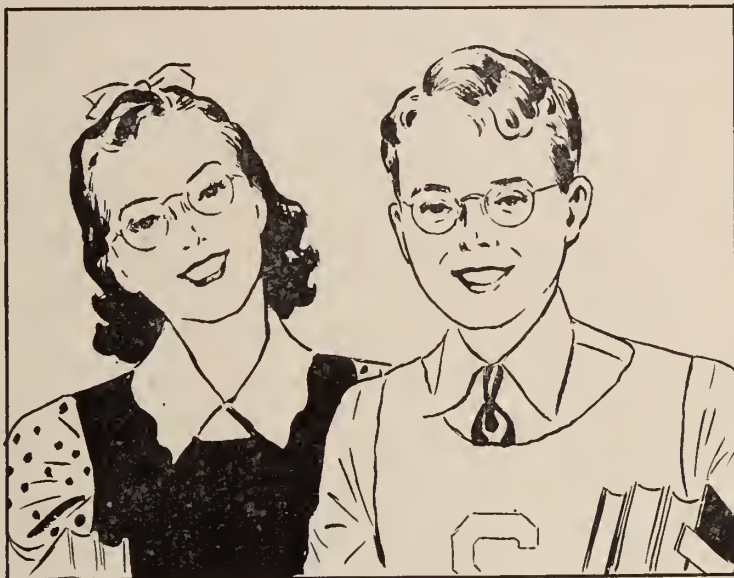
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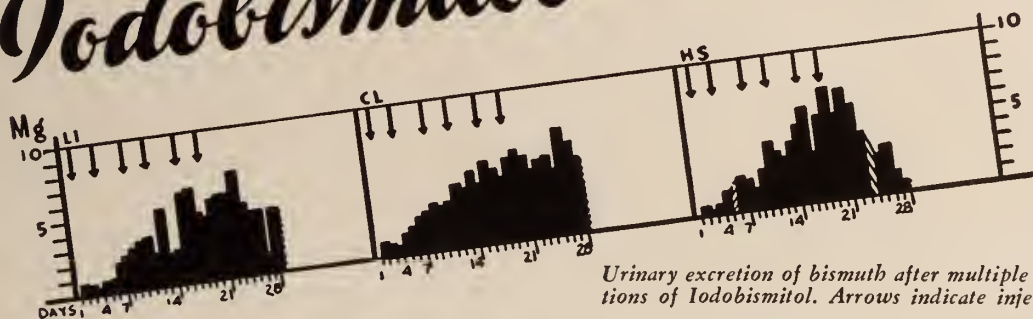
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<sup>1</sup> Sollmann, T., Cole, H. N., Henderson, K., et al.: *Amer. J. Syph., Gon. & Ven. Dis.* 21:480 (Sept.), 1937.

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# RECENT ADVANCES IN THE SCIENCE OF NUTRITION

## I. THE ROLE OF RIBOFLAVIN IN HUMAN NUTRITION

● In 1933, a series of articles on the vitamins was published, each article written by an authority in the field of nutrition. These papers served to summarize existing knowledge concerning these essential factors. During 1938 a similar series of articles has been issued. Comparison of related papers in these two series will indicate the most important advances in the science of nutrition which have been made in the course of the past five or six years.

In the first series of articles mentioned above, only two of the better known members of the old vitamin B complex received extended discussion (1). The more recent series, however, is characterized by the inclusion of a number of papers on riboflavin which, since 1932, has assumed a new significance in human nutrition (2). As compared with other factors with which it is often associated in nature, the rise of riboflavin to importance in human nutrition is somewhat anomalous.

For example, the effects upon humans of severe dietary deprivation of vitamin B<sub>1</sub> and the P-P factor are well known, in fact, such effects in themselves afford proof of the indispensable nature of these factors. While riboflavin is apparently concerned in cellular oxidation processes of mammals, the specific effect on humans of riboflavin deficiency is not known. Nevertheless, from the weight of evidence accumulated during the last five years, riboflavin is generally accepted as important in human nutrition. Authoritative opinion concerning riboflavin has been succinctly expressed as follows:

"The fact that we do not know any specific human disease due to shortage of riboflavin is entirely compatible with the view that this substance is important in human nutrition. A detailed discussion of reasons for believing that riboflavin plays a role in the life process of the human as

of other species would probably seem superfluous to a majority of readers at this date, and to a still larger majority in the future. Suffice it to point out that our species has evolved in the direction not of shortening the list of things it needs but of lengthening the list of things it can use to advantage." (2c)

Chemically, riboflavin is described as 6, 7 dimethyl-9 (d-l' ribityl) iso-alloxazine; a yellow-green, heat-stable pigment enjoying wide distribution in the plant and animal kingdoms. Many foods, therefore, of both plant and animal origin supply valuable amounts of this essential factor, specifically, fruits, vegetables, particularly the leafy pigmented types, and animal products such as milk and dairy products, meats, liver, and fish. It may, perhaps, be too early to estimate the daily human requirement for riboflavin. However, one rather liberal recommendation lists 600 units\* as required daily by older children and adults; the estimated riboflavin requirement for younger children is somewhat less (2c).

In view of the above facts, attainment of an adequate intake of riboflavin would appear to be best insured by a varied dietary regime which includes the so-called "protective" foods. In the formulation of such diets, commercially canned foods may be particularly valuable. The older "vitamin G" assays—which are now known to measure principally the riboflavin contents of foods—indicate that modern canning procedures are without significant effect upon riboflavin. In addition, many foods valued for their contribution of this factor are canned commercially and hence are conveniently available at all seasons on practically every American market. Therefore commercially canned foods may be freely used in arranging such protective diets and they should materially assist in providing an adequate supply of this newly recognized dietary essential, riboflavin.

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\*Bourquin-Sherman.

1. 1932. J. Amer. Med. Assn. 98, 2201 and 2283  
1932. Ibid. 99, 26 and 121.

2a. 1938. J. Amer. Med. Assn. 110, 1105.

b. 1938. Ibid. 110, 1188.

c. 1938. Ibid. 110, 1278.

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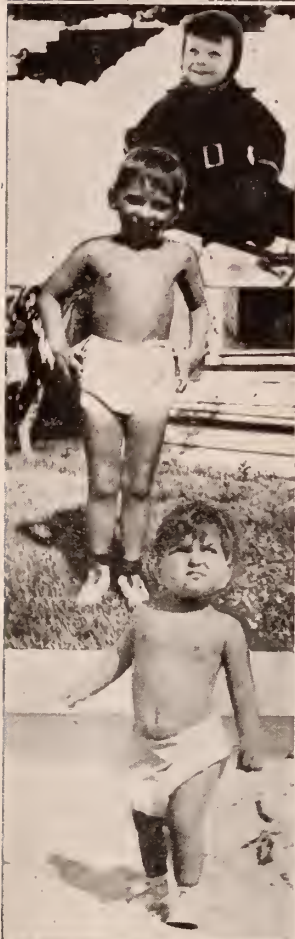
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## Are the Neuritic Symptoms of Pregnancy *due to a deficiency* *of vitamins B<sub>1</sub> and G?*

**S**UCH common neuritic symptoms of pregnancy as pains in arms and legs, muscle weakness, and (less frequent but more serious) paralysis of the extremities may result from a shortage of antineuritic vitamins, recent investigations appear to show. Although neuronitis of pregnancy has long been considered a toxemia, no toxins have ever been identified.

Clinical observations of Strauss and McDonald lead to the conclusion that the condition is a dietary deficiency disorder similar to beriberi, caused by lack of vitamin B<sub>1</sub>, complicated by symptoms which may be traced to shortage of vitamin G. They report recovery in their cases receiving this therapy, including dried brewers' yeast.

### ***Hyperemesis as Cause of Avitaminosis***

Wechsler observes that all cases of polyneuritis of pregnancy recorded in the literature were preceded by long periods of severe vomiting. "It would seem," he adds, "that because of actual starvation these patients suffered from avitaminosis and consequent neuritis," a view likewise held by Hirst, Luikart, and Gustafson. Plass and Mengert observe that the practice of giving high carbohydrate feedings for hyperemesis gravidarum is still more likely to cause avitaminoses B and G.

Dried brewers' yeast, as it is far richer than any other food in vitamins B<sub>1</sub> and G, is being used with benefit both in the prevention and treatment of polyneuritic symptoms of pregnancy. Lewy found that additions of yeast to the diet reduced electric irritability of the peripheral nerves and brought clinical improvement. Vorhaus states that he and his associates, after administering large amounts of vitamin B<sub>1</sub> to 250 patients having various types of neuritis, including that of pregnancy, observed in about 90% of cases "varying degrees of improvement, i.e., from partial relief of pain to complete disappearance of all symptoms."

### ***Need for Vitamins B and G in Lactation***

Evans and Burr, Hartwell, Sure and co-workers, and Macy *et al* are among numerous authorities who find that the nursing mother also needs supplements of vitamins B<sub>1</sub> and G, from 3 to 5 times the normal requirement. Tarr and McNeile report that the physical, mental, and emotional status of 120 pregnant and lactating women receiving Mead's Brewers Yeast and other foods high in vitamin B was superior to that of a control group of 116 women.



Since the management of polyneuritis of pregnancy is difficult at best, it would appear logical to supply those dietary substances which may safeguard against it. One of the richest and most convenient sources of the anti-neuritic factors, vitamins B<sub>1</sub> and G, is Mead's Brewers Yeast Tablets. Consisting of nonviable yeast, they offer not less than 25 international vitamin B<sub>1</sub> units and 42 Sherman vitamin G units per gram.

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## PREOPERATIVE AND POSTOPERATIVE CARE OF INTESTINAL OBSTRUCTION\*

HARRISON A. WALKER, M.D.,  
Miami Beach.

It is the purpose of this paper to deal with the subject of intestinal obstruction in its broader sense, with more particular attention being paid to diagnosis and preoperative treatment, as well as operative technique and postoperative care.

It has been a lamentable fact that, for three decades prior to 1933 there was no perceptible reduction in the mortality rate of obstruction cases. However, some reduction has taken place in the past half decade. To this advance a goodly portion of credit necessarily goes to Wangensteen and his cohorts.

For a number of years the foremost theory put forth for this high death rate was the toxic absorption from the lumen of the obstructed bowel. However, more recent research tends toward the mechanical factors of bodily upset, and disturbance of blood chemistry balance.

Wangensteen, in considering the effects of distention on the probable lethal factors in obstruction, states: "Apart from the loss of fluids and electrolytes which are of serious consequence in high obstruction alone, the chief effects of obstruction are mechanical and concern intra-enteric pressure as related to absorption, and viability of the bowel. Though it has been shown that intra-enteric pressure increases normal lymphatic absorption, there is no evidence that the abnormal lymphatic absorption occurs. Bacteria are absorbed through lymphatic channels under conditions of obstruction, but their presence has been demonstrated in mesenteric venous absorption, with increased intra-enteric pressure. As long as the peritoneal coat of the gut is intact, or the bowel is viable, transperitoneal absorption does not occur, and the patient remains in good condition. Experimental

inquiry and clinical observations indicate that the chief lethal factor in simple obstruction is permeations of a gut wall whose viability has been impaired by bacteria and other deadly agents. In strangulating obstructions, apart from blood loss factor, this too is the chief concern. It would consequently appear that the rationale of well directed therapy should be reduction of intra-enteric pressure by decompression, or release of the obstructing agent, before the viability of the bowel is impaired."

Diagnosis and treatment of intestinal obstruction requires the early recognition of obstruction. It has been said by one who is an eminent authority that the time to operate for intestinal obstruction is when you think there is an obstruction. That, of course, is a good statement only in spurring up procrastination and dilatory tendencies. Many times we may well know that the patient has an obstruction and must come to early operation. However, there are important steps to be taken to improve the patient as an operative risk: first, by decompressing the distended bowel; and second, by supplying lost blood chlorides by intravenous normal saline with glucose or Hartman's solution; and third, by transfusion.

For recognition of intestinal obstruction, the common complaints are pain, vomiting and distention. Then, we must differentiate the high and low obstruction, which is done by the character of the vomitus, the use of the stethoscope and the x-ray for gas levels, and also laboratory aids. Blood chemistry shows decreased chlorides and increased nonprotein nitrogen. Urinalysis shows a scanty urine, with albumin or casts.

The location of obstruction is differentiated by the type of vomiting and vomitus, and its rapidity of onset. Palpation and percussion as well as the stethoscope are also essential. X-rays showing gas levels, haustrations of the small and large bowel, according to the pattern of arrangement of intestinal cords described by Mall, are valuable aids.

In preoperative treatment decompression is of great importance. This is done by anchor-

\*Read before the Sixty-fifth Annual Meeting of the Florida Medical Association, held in Miami, May 9, 10, and 11, 1938.

ing a nasal duodenal tube with the suction apparatus known as the Wangensteen. But, this must be used with caution and care so that one may not cause too great a loss of chlorides, or even cause an obstruction within itself by being left anchored too long.

Contraindication for suction is: strangulation obstruction with compromise of blood supply. In acute obstruction of left colon, with enormous distention of the proximal colon, the latter is converted into a closed loop type of obstruction by the proximal competent ileocolic valve and the sphincter. It is essentially a strangulating obstruction. In such an instance, operative procedure is the choice.

It has been alleged that high obstructions are more serious in character than the low obstructions. I do not believe this idea will hold because, in low pelvic obstruction there is greater effect on the bowel wall which will lend to perforation, even with an absence of marked vomiting and loss of chlorides.

Some of the evidences of successful decompression are: cessation of gas pains; decrease of distention; visualization of gas in the colon on the x-ray film in complete obstruction; less fluid aspirated through the duodenal tube; and toleration of temporary discontinuance of suction without recurrence of pain. (Narcotics should not be given a patient at this stage, since continued pain is evidence that the decompression is not adequate. It is, however, a good plan to apply heat to the abdomen).

The use of the indwelling duodenal tube postoperatively has, beyond a doubt, reduced the amount of vomiting, or has caused a cessation of it earlier than in cases where it was not used.

Saline balance should be held sufficient to keep the kidney function and the nonprotein nitrogen in proper proportions. Normal saline, plus 5 per cent glucose, may be alternated with distilled water, with or without glucose; also with Hartman's solution. More salines

may be required if the duodenal tube is kept working constantly.

Blood transfusion is important in supplying volume, constituents, and to combat infection.

Operation, until recently, has been the only remedial agent of value in treating patients with bowel obstruction. Operation still is, and will continue to be, the chief mainstay of therapy in most forms of bowel obstruction. In strangulating obstructions the mortality is largely that of delay. In simple obstruction a wise choice of operative procedure will salvage a large number of late cases. The therapeutic measures indicated then are:

1. Adequate replacement of fluid loss, by the liberal para-oral administration of saline solution in all instances in which vomiting has been a feature.
2. Early relief of distention by measures which preserve the sterility of the peritoneal cavity.
3. Restoration of blood loss by transfusion, in strangulating obstructions.

It is also worthy of mention to note that in the operative technique it is important to prevent spilling or soiling in the peritoneal cavity, since the aseptic consideration here is just as important as in doing a perforated ulcer operation, the protection of an appendix stump, or the cervical stump in hysterectomy.

When the obstruction is in the large bowel beyond the cecum, and is complete, it is a good practice to relieve it by cecostomy, performed by the Witzel method; or, by amputating the appendix and dilating the appendix stump sufficiently to permit a 14 to 18 size soft rubber catheter to be inserted several inches into the cecum, and anchored with two purse-string sutures. When this has accomplished its purpose of relieving the distention, and time has permitted correction of blood chemistry, if further operation is required, it may be done with greater safety and lower mortality.



In case of strangulation of the bowel, with gangrenous process already having occurred, it is a better procedure to do cecostomy, colostomy, or ileostomy, than to try to resect bowel with an attempt at anastomosis of bowel which is not viable, or whose wall has been affected by distention and its mesenteric blood supply interfered with sufficiently to make it improbable that sutures will hold.

Gatch states: "When mesenteric vessels are obstructed, nothing but transperitoneal absorption can take place. This is probably slight, because patients often live for days with pieces of gangrenous intestine without showing noteworthy signs of intoxication. The omentum can isolate a loop of gangrenous bowel as readily as it can an abscess.

"Distention itself, if due to an intra-intestinal pressure higher than the diastolic blood pressure, prevents all absorption from the bowel by way of its mesenteric vessels, even though the mucosa is damaged. Since untreated bowel obstruction is accompanied by a marked fall in the blood pressure, it is probable that the intra-intestinal pressure in any damaged loop of bowel will be as high as the diastolic blood pressure; and that, therefore, no absorption from it can take place."

Absorption of toxins can occur only in the presence of a devitalized intestinal mucosa, and an adequate circulation through the bowel wall. These conditions are present when the intestinal mucosa has been partially devitalized by prolonged and great distention which is rather suddenly relieved. When the obstruction is between the cecum and pylorus, gastric lavage is indicated. It is reported by Gatch that some cases of obstruction, wherein a band or kink was the cause, have been relieved without operation, but by continuous gastric lavage decompression.

The position of the patient postoperatively is a most important point. In ileus with distended stomach, have the patient in a reversed Fowler position—with the feet considerably higher than the head—so as not to have the weighted stomach pulling down on the duodenum, kinking it, causing a mechanical obstruction. This point was very well demonstrated by Dr. Thomas Otto in a recent case

in which he was in consultation with Dr. Walter Jones and myself. I shall appreciate his comments on this in more detail.

#### CONCLUSIONS

There are three points of paramount importance in preoperative intestinal obstruction cases, namely: early diagnosis and location of the obstruction; improving the patient as an operative risk by decompression, and improving the blood chemistry; and transfusion, both for improving the blood chemistry as well as to combat infection and absorption.

In operative procedure the point of importance is to operate in sufficient time after the patient's condition has been made the most favorable possible. First should be the election of site for the abdominal incision, after having located, if possible, the point of obstruction. Then determine what operative procedures are most indicated,—whether or not to resect, relieve bands, kinks, or do cecostomy, colostomy or ileostomy.

In postoperative care it is again necessary to consider decompression, holding the blood chemistry balance, and transfusion; also, to pay definite attention to the position of the patient in bed.

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605 Lincoln Road Bldg.

#### DISCUSSION

*Dr. Lloyd J. Netto, West Palm Beach:*

Due to unavoidable circumstances I was called away for the whole of last week and did not have a chance to review the paper in order to prepare a discussion. I am very glad I have had the opportunity of hearing Doctor Walker's paper.

There are one or two things I have thought of that I would like to leave as suggestions. The first thing is that regardless of all the refinements in measuring blood chemistry, all refinements in diagnosis, all the refinements in technique and with instruments of all kinds, the mortality is still too high. That, of course, is true of many other things. Eventually these refinements will be brought to a point where the mortality will be greatly lowered.

I have had very little experience with preoperative decompression methods. We are in a small city and do not have a comparatively great number of cases of obstruction to deal with. However, I believe that some scattering reports have come up from some clinics, particularly Tulane University, in which they are beginning to consider that this preoperative decompression has something to do with increasing the mortality rather than preventing it. On one thing I believe you will all agree—that intestinal obstruction is an acute abdominal condition the same as an acute appendicitis and any unnecessary delay is dangerous. However, undue haste is not indicated.

When a diagnosis is definitely established and proper operative attack selected one should proceed immediately. Under all circumstances anesthetics have to be carefully considered. The technique in the hands of an experienced operator is not a long drawn out affair. It has been my experience with most of these cases that if you have made a definite diagnosis and determined what to do and it is done promptly the patient will usually get well, because it is not the obstruction itself that causes death but the absorption of toxins following the destruction of the function of the intestines that causes death in these cases. The simplest ones of course are those that get a quick diagnosis, and prompt treatment.

I had one case in which the patient was operated on at least two years before I saw him for the first time, an appendix drainage case. I have since operated on him three times for obstruction. He gets well promptly but I hope I never have to do it a fourth time.

I am sorry that I did not have time to work up a more intelligent discussion. It has been a pleasure to appear on the program.

*Dr. Edward Jelks, Jacksonville:*

About fifteen years ago at a meeting of the Florida Medical Association Doctor Alsbrook very wisely expressed the opinion that every annual session of the Association should have on the program at least one paper dealing with the subject of intestinal obstruction. Obviously, his idea was that a condition which carries with it such a high mortality rate and presents so many difficulties in the handling

of the individual cases, could not be talked or heard about too much.

Everyone of you who has dealt with the problem of intestinal obstruction at times, at least, must have felt as did Thomas Paine during the American Revolution when he said "These are times that try men's souls." We can talk and read about the principles or the treatment of intestinal obstruction, experiments on animals can be done which seem to prove certain points about intestinal obstruction, but when it comes to the decision of what is to be done for the individual patient, it is sometimes quite difficult to know just what type of obstruction is present and what kind of treatment is to be instituted.

As Doctor Walker was reading his paper my mind went back fifteen years to the same meeting, when there was a paper being read on the same subject before this Association. My memory makes clear the marked difference in the approach to the subject in these two papers. In the earlier paper the thing to do and follow, always as a rule was an enterostomy as early as possible. The paper today lays very little stress upon that procedure. It was mentioned but more emphasis was put upon another procedure, which indirectly does the same thing, that is, relieves the pressure on the bowel. Certainly if decompression is the thing to do, and the general thought today is that it is desired in most cases, it is better to accomplish this end without an enterostomy; first, because it makes a surgical operation for the relief of the obstruction more difficult and, second, to have made an enterostomy sometimes gives a surgeon a false sense of security, which might influence him right away from the detailed, repeated, and careful observation which a patient for intestinal obstruction must have, if he is to receive the most adequate treatment at the proper time.

Recently the idea of decompression with a tube has been extended to the use of a double tube eight to ten feet long, with a bulb at one end which is carried down through almost all of the small intestine by peristalsis, so as to accomplish a complete emptying of the bowel.

Enterostomy should, of course, be considered along with other methods of decompression in preparing the patient for operative re-

lief of the obstruction. Of course, a tube in the bowel does not cure the patient of the obstruction. Operation upon the obstructing point itself should be done at a time when the physiology and mechanics of the bowel are as near normal as it is possible to make them.

In closing, I would like to stress one other point. When the patient has recovered from what you thought was intestinal obstruction, don't discharge him until you know what that obstruction was. We have seen two patients during the last year, each with cancer of the large bowel who had four to five months previously, an attack of rather severe obstruction of the bowel. The suffering was relieved by the tube and the swelling around the tumor area resolved sufficiently to give the patient symptomatic relief, but no immediate effort was made to determine definitely the diagnosis.

If the profession will continue to give consideration to the problem of intestinal obstruction, perhaps in another fifteen years' time there may be as great a difference in the treatment of this condition as there is between the way it is done now and what was thought wise to do for the patient fifteen years or more ago. Certainly, at the present time the best we can do, in accordance with what Dr. Walker says, is to get the patient in good operative condition by the simplest method possible, do the least damage possible to him, and then as early as it is advisable, relieve the obstruction, surgically.

*Dr. W. McL. Shaw, Jacksonville:*

Doctor Walker as usual has given us an excellent presentation, and almost all of the essayists so far have mentioned the use of the x-ray in diagnosing intestinal obstruction. I won't bore you with a repetition of the x-ray findings except to say that it does not take elaborate and expensive x-ray equipment to diagnose these conditions. Those of you who are in the smaller centers may have only a portable machine, but the surgeon will be glad if you can diagnose these conditions or rather be glad of the help that the x-ray man can give him in locating these obstructions.

If you cannot get your patient to the x-ray

room carry the portable machine to his room, and get films in several positions. It will also help if you get semi-erect or erect films which will show fluid levels.

There is one point that I wish to bring out in particular in this flat film work on the abdomen. I will show two slides demonstrating a possibility which we should always keep in mind in searching for such conditions in the abdomen, namely, perforation. This first slide shows a young man about 26 years old who had a history of indigestion. He had passed tarry stools. This particular night he went to bed and was nauseated. Later, around midnight he had a tearing sensation, as he expressed it, in his abdomen. A surgeon was called and patient immediately sent to the hospital. Five hours later we were able to get these films. I will show you the slides which I hope will bring out the point which I think is well worthwhile carrying home with you,—that is, an accumulation of gas or air beneath the diaphragm in the peritoneal cavity. This is a rare finding but an absolute diagnostic point of evidence. When you get it, there is nothing that can cause it but a perforation. (*Slides*).

*Dr. Harrison A. Walker, concluding:*

I want to thank all of the discussors for the various points they have brought out.

I hope I made it sufficiently clear that I am not advocating delay of operation in intestinal obstruction any longer than a few hours or whatever time would be required to run a blood chemistry and correct the blood picture and to do a decompression if the type of obstruction requires it.

I heartily agree with the older principle that we have adhered to for a long time—that procrastination, misdiagnosis, or any delay in operating in the case of an obstruction, is bad practice. If it is possible to make a differential diagnosis or locate the obstruction by the various methods mentioned, I feel it is justifiable to use a few hours in doing blood chemistry, supplying the patient with what he has lost from his blood either by infusion or transfusion, and to do a decompression if that is indicated. This will greatly help to salvage more of these patients and reduce our mortality rate.



## AMEBIC DYSENTERY CARRIERS\*

M. J. Myres, M. D.,  
Daytona Beach

The attention of this group is directed to the control of this dysentery carrier, because the disease is widespread in the United States, as it is in many parts of the world.

Until recent times diagnosis and recognition of the disease has not been general. The reason for this lag is that searching for the ameba in the stools is technically a difficult task. Only in about twenty per cent of cases brought to autopsy has the ameba been actually seen in the discharges before the patient died. But in 1930 Craig<sup>1</sup> reported a successful method of detection of infestation by means of specific antibodies in the blood. Since then the task of diagnosis has become sure and easy and control of the carrier is now a possibility. As you all well know, the carrier shows no symptoms. You can well understand how useless an ameba survey would be in a large community when only one case in five is recognized and how great and useless the cost of such an investigation, when four hosts would escape to spread the disease, and only one be brought under treatment to rid him of the parasite.

Three cases in the vicinity of Daytona Beach have been brought to my attention in the last year. The last was a fulminating one, the patient dying in four days. So serious and explosive were his symptoms that they aroused my interest and I took the problem to Dr. Dan Cone, our State Epidemiologist. A week later I was ordered to Tulane University for summer training and found that the disease was arousing intense interest in the Fourth Corps area, a large portion of the course being spent in the study of the ravages of this parasite.

The disease is of special concern to those towns dependent on tourist trade. Let me recall to your memory how a large number of tourists succumbed after visiting the last world's fair at Chicago. The City Health Officer and the corporation Chicago itself were sued because of this occurrence, unsuccessfully let us hope.

The parasite belongs to the simpler forms

\*Read before Florida University Short Course, Sewage and Water Treatment, Daytona Beach, May 24, 1938.

of animal life. Many amebae are seen in stagnant water and in the dejecta of animals. Differentiation of the *hystolitica* is difficult. It is made by its size, which can best be remembered by comparison with that of the red blood cell. To be a pathological ameba, it must be shown that it feeds on red blood cells. These two rules are safe and simple. Though the disease is widespread, having been found in most population centers of tropical and temperate zones, it is endemic in the coastal plains of tropical countries. Those having seasonal heavy rains are most heavily infested. The rains wash the parasite from stagnant pools and prevent early death of the organism by drying out. In India and many other tropical countries the white man moves to the hills in the summer time to escape dysentery. This migration has given us the unforgettable *Plain Tales from the Hills* of Rudyard Kipling.

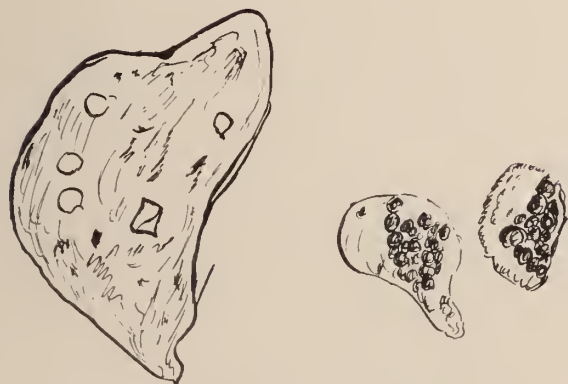
Simmonds<sup>2</sup> tables show heaviest incidence in April and May. The curve sinks due to summer's heat and drought to rise with the oncoming wetness of November. South America, India, Egypt, Mexico and the Philippines are heavily infested but no climate, except at high altitude, is exempt. Natives of tropical countries are more susceptible than whites, probably because of hygienic and sanitary imperfections. Sex has a definite influence on incidence, recorded male cases numbering five times those in females. Alcoholics seem especially prone. The average age incidence is 37, ranging from 14 to 65. The disease is rare in infancy. Outdoor occupations predispose the worker to infection. Sex, alcohol, age, occupation and climate all point to the young, daring and venturesome youth who works hard and drinks hard.

Wenyon & O'Connor<sup>3</sup> found that of 398 cooks in the British India Army, nine per cent were infected. I treated a series of cases after the Spanish American war. The French Colonial troops shared the disease with their allies in France and it was my misfortune to have a brisk dysentery which took me to the Red Cross Hospital No. 3, for five weeks. The discharges were continuous and bloody, and cramps and pains were almost constant.

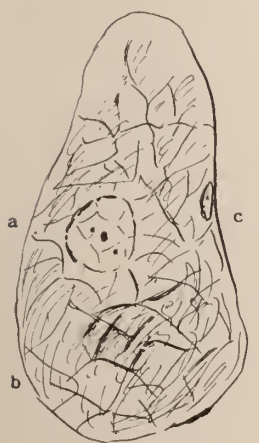
Clinically we group cases by their behavior, time and severity being the governing criteria.



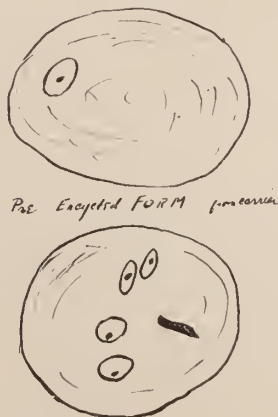
*Endameba histolytica* (after Shaudinn)



*Endameba histolytica* (after Shaudinn)



*Endameba histolytica*  
(after Shaudinn)  
(a) Poor chromatin in  
nucleus  
(b) Reticular network  
(c) Red cell



Encysted form

#### ACUTE AMEBIC DYSENTERY

Acute Primary  
Subacute Relapsing

#### CHRONIC AMEBIC DYSENTERY

Active and Relapsing  
Latent

Atypical Forms

To these classical forms let there be added:  
Chronic Amebic Infestation with  
Adynamic Constipation  
Carriers

The incubation period is a moderately long one, averaging 64.8 days, varying from 23 days to 95 days after the first seeding with the parasite. This work was done by Walker & Sellards,<sup>4</sup> who parasitized 20 Filipino convicts. The onset of the acute primary form is stormy with high fever, nausea, vomiting and bloody flux. Cultures of the stools made in the first four days are positive for various forms of *Bacillus Dysenteriae*, a symbiotic infection. Stools examined after the fourth day show the true amebic character of the infection. Prostration is extreme and death may occur at any time after the third or fourth day. The autopsy will show ulcers due to the burrowing of the organisms through the coats of the intestines. If the intestine be held to the light, the base of many of the ulcers are as thin and translucent as is parchment paper. Despite this fact, perforation of the bowel is a rare complication. Prompt use of emetine injection generally stops the bloody diarrheal discharge and saves many of the victims who may thus recover or change to a form less fulminating.

The acute relapsing form shows many of the same symptoms but in less severe degree. Periods of bloody diarrhea alternate with mild prostration, each lasting from a few days to two or three weeks. Constant bowel derangement, fever and digestive disturbance alternating with dysentery undermine health and strength. If not successfully treated, such cases enter a chronic stage.

The chronic relapsing type is the one most frequently treated by the doctor. Acute symptoms subside and the patient thinks he has recovered, although at any time, even after a term of years, an acute relapse, resembling the acute form supervenes, taxing bodily vigor and enterprise.

In the period of 1904 to 1908, while an in-





#### CONCLUSION

Workers in India found nine per cent infestation in army cooks and food handlers. The incidence of amebic disease is widespread. It has appeared in this community. Classification of symptom types has been presented and treatment of the disease is outlined. A method of survey of the state for the disease is practicable and not too difficult.

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#### DISCUSSION

*Dr. J. N. Patterson, Director of Laboratories,  
State Board of Health, Jacksonville:*

My remarks are made extemporaneously for I have for the first time heard Doctor Myres' paper and think he is to be congratulated on his excellent presentation of the subject to a lay audience. It is well that this subject is brought before men interested in our water supplies and sewage disposal.

I think it is well to stress the fact that the danger of infection does not come from the acute cases of amebic dysentery but rather from the chronic cases and the carriers. In the acute cases of amebiasis the parasite is in the trophozoite or motile stage and is destroyed on ingestion by the gastric juice. However, the *Endameba histolytica* in the chronic cases and in the carrier state is in the cystic stage and these cysts are unaffected by the gastric juice.

Our state laboratories are at a great disadvantage in making a diagnosis of amebiasis because for best results a fresh stool is necessary and most of our work is done on stools 24 hours or more old. In the acute stage of the disease it is absolutely necessary to have a fresh liquid or semi-solid stool to find the motile trophozoites. It is very helpful in the chronic cases and in the carriers to have a fresh specimen of stool, which as a rule is either semi-solid or formed, for the cysts undergo changes on standing that make their identification difficult. The container

used in the collection of feces should be clean but contain no antiseptic or preservative. A saline cathartic, if not contraindicated, will aid in the diagnosis by the passage of more trophozoites in the acute stage and more cysts in the chronic stage.

The Craig test for amebiasis is a complement fixation test similar in principle to the Wassermann test. The technique of this test is difficult and the reliability of the results varies markedly in different laboratories. Craig admits one of the difficulties preventing the widespread use of his test lies in the preparation of one of the reagents used (the antigen). Our state laboratories do not use the complement fixation test for syphilis. For us to do the Craig test would mean a complete, time-consuming setup and not just the addition of a couple or more tubes.

Amebiasis is a wide-spread disease in the tropics and sub-tropical regions and is not uncommon even in the northern states.

A point of practical importance that it is well to stress is that chlorination, even a concentration of chlorine 100 times that usually used for water purification, does not injure the cysts of the *Endameba histolytica*. However, boiling of the water will kill these cysts.

#### HAY FEVER AND BRONCHIAL ASTHMA\*

WITH REPORT OF CASES

Graham E. Henson, M.D.,  
Jacksonville.

While the allergic diseases do not very materially affect our mortality rates it may not be fully realized what an important factor they play in our morbidity rates and, in terms of economic loss, the immense toll exacted from the wage earner. Time will not permit a discussion of the general subject of allergy so I shall limit myself to a brief consideration of what constitute two of the principal allergic diseases, namely: hay fever, or better termed a pollinosis; and bronchial asthma.

#### HAY FEVER

Hay fever can not be regarded as a major problem in this section of our country so I shall dwell on it only briefly. It is probably the simplest of our allergic problems. I refer,

\*Read before a meeting of the Staff of the Duval County Hospital, Jacksonville, June 21, 1938.

of course, to the uncomplicated seasonal pollinosis, excluding cases of vasomotor rhinitis and chronic sinusitis with a superimposed seasonal pollinosis, for while these patients get seasonal relief by desensitization with incriminated pollens we are not assured of giving them the permanent relief we are able to promise the patient with an uncomplicated pollinosis.

Various tree grass and weed pollens are all responsible in this state for producing hay fever subjects. In a general way the tree pollens are at their maximum production in the early spring, the grasses in the late spring and early summer, and the weed pollens in late summer and the early fall months. We have found that the common ragweed, the spiny amaranth and Bermuda grass are responsible for the greater number of cases in Florida, probably outnumbering all other pollens combined.

Let me cite a case of simple uncomplicated pollinosis in a young man of 23 years. He gave a history of developing the characteristic symptoms of an acute pollinosis the day following a round of golf. This had happened for the past five or six spring and summer seasons. He gave positive reactions to red top and Bermuda grass. Desensitization was begun some two weeks ago. He has been on a golf course almost daily for the past ten days and has had a complete cessation of his usual exacerbations throughout this period. It is not unusual for a hay fever subject to get relief in this manner after receiving but a few hundred pollen units or less.

In this clinic we have been handicapped not a little by being unable for financial reasons to furnish the necessary pollen extracts for desensitization but in those few cases where the patient was able to purchase the extracts we have obtained gratifying results. Having determined the specific tree, grass or weed pollen or pollens to which the patient gives positive reactions, desensitization with the incriminated pollen will in the vast majority of cases result in a complete cessation of symptoms. While a single pollen is generally responsible for the syndrome it is well to bear in mind that there may be double or multiple tree, grass or weed pollens responsible, and in desensitizing we must be governed accordingly.

There are three methods of desensitization: the perennial, the coseasonal and the pre-seasonal. While many authorities consider the perennial method the one of choice nearly all agree that it is not the most practical, as obviously it is a hard matter to maintain a patient "pollen-conscious" for twelve months in the year, nine or ten of which he is free of symptoms. In resorting to coseasonal desensitization, by the same line of reasoning, it is as easy to secure 100% cooperation from the sufferer during the months of intense symptoms. However, while it is possible to greatly ameliorate his symptoms by this method, we are unable to give him the complete relief accorded patients treated by the preseasonal method. Thus, coseasonal desensitization should be used only on those subjects who come under our care just prior to or during a hay fever season.

It is seen that the method of choice lies with preseasonal desensitization. In selecting this method it is advisable to begin desensitizing from seven to eight weeks prior to the period that the incriminated pollen or pollens are known to be at their maximum production. It is customary to institute treatment with five pollen units, doubling the dosage twice weekly for two weeks, then increasing the two succeeding doses to sixty and one hundred units, again doubling each dose for the succeeding two weeks. A dosage of eight hundred units has now been reached and is increased in biweekly doses to one thousand, fifteen hundred, two, three and four thousand with the maximum dose of five thousand units being so timed as to approximately correspond with the maximum pollen production of the season. During this desensitization period any definite constitutional reaction calls for the succeeding injection to contain the same number of pollen units as was previously administered. If and when necessary there are many palliative measures which will give these patients temporary relief but it is not within the scope of this paper to enter into a discussion of these measures other than to mention parenthetically that the too frequent habit of resorting to cocaine sprays cannot be too heartily condemned. It is more than likely to create future trouble and is comparable to the indiscriminate use



of morphine in the treatment of bronchial asthma to which I will later refer.

It should be emphasized that by the proper timing of specific desensitization the necessity of having to resort to palliative measures will be reduced to a minimum. Again, the standard of dosage is not necessarily an arbitrary one; it will have to be deviated from to fit the individual case. What must be kept constantly in mind is that the maximum massive doses be so timed as to correspond with the height of pollen production.

#### BRONCHIAL ASTHMA

In bronchial asthma we are dealing with a disease that produces untold suffering and one that takes an immense toll from an economic viewpoint. In attempting to arrive at the etiology, each case is an individual problem. In many cases the study will tax to the utmost the resources of the physician and the patience of the sufferer, while in others the solution is ridiculously simple.

History is an important factor and a careful record should be made of all previous illnesses. In children we often ascertain that the first attack of asthma shortly followed one of the acute illnesses common to childhood—notably measles and whooping cough. In others there appear to be no relation between the original onset and any previous illness. Whenever practical an x-ray study of the chest is desirable. It is my custom to have these patients furnish a complete list of all foods that ever enter into their dietary. To fortify this portion of the study I have found it useful to have the patient record on small blanks furnished for the purpose an itemized list of foods eaten at each meal from day to day for a period of two weeks. With this preliminary study completed, cutaneous tests of all food proteins; tree, grass and weed pollens; all epidermal protein extracts; the various miscellaneous protein extracts known as causative factors and the bacterins, are applied. An important factor, more especially in young children, in carrying the investigation to a satisfactory conclusion is to gain the confidence of the patient. The mere thought of having to submit to 150 or more cutaneous tests, to say nothing of the intradermals to follow, while no great pain is experienced would be terrifying to almost any child and

to not a few adults. Each individual has to be handled accordingly. By commencing with as few as four or five tests, the most apprehensive child can gradually be given an increased number of tests so that within a few days as many as thirty or more can be applied without difficulty. Reactions are, of course, recorded as the procedure continues. The cutaneous tests are followed by an intradermal on all negative and on all those giving a suspicious reaction. In the first series of tests a control should be employed but is not necessary in subsequent sittings. My experience has taught me to consider it a great error to rely on cutaneous tests exclusively in an effort to demonstrate the causative factor or factors in any allergic manifestation. Limiting the investigation in this manner is in my opinion comparable to the examination of a single specimen of sputum in a suspected tubercular subject—finding no tubercle bacilli and pronouncing the subject free of tuberculosis—or in a case of suspected malaria, to examine a single thin blood smear and finding no organisms, to promptly rule out this infection.

While some difference of opinion exists as to the possible danger of anaphylaxis from the intradermal injections of protein extracts, the previous application of the cutaneous test practically eliminates this possible danger. This is one of the advantages of the cutaneous test. Another is that where a positive reaction is obtained it eliminates the need for an intradermal which is a decidedly more painful procedure.

The allergic bronchial asthmas may be classified as being due to: a single or several food proteins; an epidermal irritant, such as cat or dog hair; any of the miscellaneous proteins such as orris root; bacterins; a combination of two or more of the above; and the tree, grass or weed pollens.

#### CASE REPORTS

Illustrative of a single food protein as the factor is the following case:

Early last winter in my private work I saw a lad of fifteen years with a history of having had attacks of asthma on an average of twice weekly for the preceding four years. His previous history held nothing of special interest. He was well nourished, intelligent, and in spite of his handicap had been able to keep up with his school grades. He was given a complete cutaneous and intradermal study, being negative to all proteins with the exception of eggs, to which he gave a



one-plus positive cutaneous and a four-plus intradermal. He was placed at once on an egg-free diet which excluded all cakes, pastries, custards, consommés cleared with egg albumin, in fact all food items containing any egg whatsoever. His attacks promptly ceased and he attended school with no interruptions for about eight weeks. At that point he ate some cookies in which egg was an ingredient, developing an attack of asthma within a few hours. He has since maintained an egg-free diet, both he and his mother being unusually co-operative. He has now gone for three months with a complete freedom of any asthmatic symptoms.

At this point let me say that no single article of food should ever be withdrawn from the diet simply because it is known to be a frequent cause of asthma. I have in mind the case of a child eight years of age who on the advice of her physician had not eaten any eggs in two years. A study of her case determined she was not allergic to the egg proteins but proved to be a bacterin case responding well to an autogenous vaccine.

Another interesting type in the food allergy class was the following case:

H. W., aged 26, had a history of asthmatic attacks recurring at least once weekly over a period of six years. He gave negative reactions to all food proteins except rice, to all other proteins and to tree, grass and weed pollens. The elimination of rice from his diet had little if any effect upon the frequency or severity of his attacks. With the knowledge that an individual allergic to one of the grains may be allergic to others in spite of negative cutaneous and intradermal reactions, all grains were excluded from his diet. His attacks ceased and he has had no symptoms for over a month. This is probably too short a period to classify the case as cured but it is three times as long a period as he had gone without an attack in over five years.

Such a case leads the discussion into the channel of experimental diets, but time will not permit me to dwell on this phase of the study of asthma other than to mention that in many of the obstinate cases we are unable to incriminate a food or foods responsible for attacks and only with experimental diets can the offending foods be determined.

Illustrative of the type allergic to the epidermal proteins is that of J. F., a boy of 10 years. He gave a history of having his original attack six years previously and recurring on an average of once a month. My early study developed that he was sensitive to dog hair and further investigation was suspended at the request of his mother who recalled that the only time the home had been free of a dog was over a period of eighteen months during 1936-1937, while living at a nearby seaside resort. During this time the child had been free of asthmatic attacks, but the mother had attributed this to the fact that they were living at the seashore. At the time he came under my observation there was a dog in the home but he has since been sent away, and the child has had no recurrence for over seven weeks. It is as yet too early to definitely incriminate dog hair as the sole etiological factor but the evidence is very suggestive.

In our work at this clinic it has been noted that there is a preponderance of bacterins as a causative factor over any other. To just what extent this may be influenced by the social strata is problematical but I am inclined to think it may be a factor. These patients are, of course, all treated with autogenous vaccines. The dosage has to be varied, dependent upon reactions. They are all started off with minute doses, gradually building up to the maximum. The desired maximum is found to vary considerably, some patients tolerating a maximum dose of 15 minims of a standardized vaccine containing 3 billion organisms to the mm., while others will not tolerate more than 6 or 7 minims. During the last 15 months we have admitted to this clinic and placed on bacterin therapy 45 cases, the length of time under treatment varying from a few weeks to one year. Of this number 7 have been apparently cured, 11 under treatment for four months are showing definite improvement, 6 have shown no improvement after one year or more of treatment, 15 failed to cooperate or passed from observation, 1 died, and 5 have been treated for an insufficient period to warrant any conclusions.

A very large majority of asthma cases due to bacterins are of many years' duration. The patients have generally developed a bronchiectasis or some other pulmonary complication, and there is of course no treatment which will permanently rid them of their trouble. Even these patients, however, frequently secure considerable relief from an autogenous vaccine. We have many such patients under treatment in this clinic and we find that many of them are subjected to fewer and less severe attacks while taking their vaccine than during lapses from treatment which occur from time to time for one reason and another.

Just a few words regarding the giving of relief to our asthmatic patients. Our sheet anchor is, of course, adrenalin. I am rather inclined to think that the tendency is to give this in too small doses. I have found that in the adult, 15 minims of a 1:1000 solution the most satisfactory dose. Sodium iodide given intravenously, 15½ grains in 10 cc. of normal saline, will very often give not only quick relief but also a lasting one. I shall not enumerate the various ephedrine compounds

put up by the various pharmaceutical houses. Some patients appear to get relief from one preparation and others from another.

In conclusion I cannot too strongly emphasize that the use of morphine should be held in reserve as an absolute course of last resort. The use of this drug until all other possible measures have been tried cannot be justified. I regret to say that I have found its rather promiscuous use altogether too frequent and if the few minutes I have been privileged to talk to you gentlemen this evening results in nothing but my message reaching and influencing those who follow this pernicious habit, I will feel that the time has been well spent.

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438 St. James Bldg.

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## THE FLORIDA TUBERCULOSIS CONTROL PROGRAM\*

J. ARTHUR MYERS, M. D.,

President National Tuberculosis Association,  
Minneapolis, Minn.

The dedication of this sanatorium marks a significant event for the tuberculosis control program of Florida and the nation. Although this is the first sanatorium in Florida it is far from the beginning of anti-tuberculosis work in the state. Members of the Florida Medical Association have long employed the modern methods of detecting and treating tuberculosis. The Florida State Health Department has, for years, had a fine reputation among health workers everywhere. During the past year it was my privilege and pleasure to review the program which the Division of Tuberculosis, directed by Doctor Logie, had prepared. When this program has been carried out, control of tuberculosis in this state will be materially aided.

In the winter of 1935, I was honored by an invitation to address the annual meeting of the Florida Tuberculosis and Health Association. For a long time I had known of the worthwhile activities of this organization; of the loyal workers who had gone

throughout the state, often at considerable sacrifice, to inform the citizens of the prevalence of tuberculosis and of the dangers to subsequent generations if the disease was not controlled. I also knew that during the preceding year approximately 1,110 persons had died of tuberculosis in this state. Throughout the meeting it was obvious that your workers thoroughly recognized the problem and the need of sanatorium facilities. Following the annual banquet in the Angebilt Hotel on the night of April 2, 1935, Miss McCormack, now Mrs. Pynchon, arranged a conference to discuss plans for the building of a sanatorium. Several months later, Mrs. Murray L. Stanley, Mr. W. E. Edwards, and Dr. Arnold S. Anderson were appointed to the State Tuberculosis Board, with jurisdiction over construction and personnel. The membership of the Board insured the most fitting decisions on every phase of the undertaking. In the brief period from April 1935 to the first of January 1938, the plans were made and the institution completed. The buildings and equipment of this institution rank it among the finest of its kind in America.

Having the buildings well planned, the members of the Tuberculosis Board were aware of the fact that the institution would be of little avail unless it could be directed by one who is expert in this field. The Board members began to look about the country for a superintendent and medical director. Because of the delightful atmospheric conditions, the fine tuberculosis work that had preceded, and the marvelous equipment for a state sanatorium, large numbers of physicians were desirous of becoming superintendent of this institution. The Board had no small task in weighing and evaluating the qualifications and the recommendations of many applicants. No tuberculosis board ever manifested a keener sense of values or finer judgment in selecting a superintendent than did your Board, when its choice from the nation fell on Dr. R. D. Thompson. He has a large fund of knowledge about tuberculosis in all of its phases; moreover, he knows the practical application of this knowledge. He has a sympathetic understanding of the tuberculous patient's problems, and he radiates this

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\*Read before the dedication ceremonies of the Florida State Sanatorium, Orlando, Florida, January 3, 1938.



to the personnel with whom he works. This, and much more which could be truthfully said about Doctor Thompson, insures the successful operation of this institution.

The building of the first sanatorium in any state is usually the result of years spent in educating and organizing various groups of workers. Dr. H. Longstreet Taylor went about the state of Minnesota for fourteen years at great personal sacrifice before he convinced its citizens that an appropriation should be made for the building of a sanatorium. In Florida Mrs. Pyncheon has worked with committees of the State Medical Association, various other organizations and individuals, to bring about the building of this institution. I am convinced that it is to her more than any other one person that the citizens of Florida are indebted for a tuberculosis program which is now outstanding in the nation.

A sanatorium for the tuberculous has a two-fold object: the first is to prevent the spread of tuberculosis in the homes and in the communities where the patients reside. Tuberculosis is a highly contagious disease and no person who has it in communicable form can come in contact with persons in his community without some of them later falling ill from the same malady. It is a disease that does not have a fixed incubation time like diphtheria and typhoid fever; with these diseases it is only a matter of a few days after exposure until illness appears among those who contract it, whereas, with tuberculosis it may be one year or fifty years after exposure before illness appears. This fact has made it difficult for the public to look upon tuberculosis as contagious and, therefore, communicable cases have been permitted to remain in their homes, expose members of their families as well as others in the community, and perpetuate the disease in the family and the community. Families in which persons have died of tuberculosis through many generations are numerous. The only possible way to control the disease is to break or prevent contact between those who have it in communicable form and those who have never been contaminated with tubercle bacilli; in other words, if every person who has communicable tuberculosis in the state of Florida could be so treated or isolated that

he would not spread his germs to others, the disease would quickly become rare in the general population.

Tuberculosis is so insidious in its onset that often, in fact usually, it has reached an advanced and communicable stage before its symptoms become sufficiently significant to cause its host to go to his physician for an examination. Since 80 to 85 per cent of the patients who enter the sanatoriums of this country have moderate to far-advanced disease on first examination and their best chances of recovery already have been lost, those who do recover do so only after long periods of absence from their work at great expense to themselves and their communities and often only through the most drastic treatment. The medical profession is criticised for this predicament because it is generally believed that such persons had previously reported to their physicians, who had overlooked tuberculosis. The truth is, the majority of them had slight or no symptoms until their disease was advanced and, therefore, no previous examinations were made. It is true that a minority have reported to physicians and their disease was considered insignificant or they were not adequately examined for tuberculosis but this is not the chief cause of this serious situation; the main cause was and still is the nature of the disease. The chronic type of tuberculosis of the lungs, which is the greatest offender from the standpoint of contagion, is usually present and gradually progressing over a period of two or three years before it causes any serious incapacity of the individuals being attacked. These apparently healthy persons are often spreaders of the germs and may be spoken of as carriers in the same sense as we speak of diphtheria or typhoid carriers. Some of them later fall ill, after which their disease is recognized; others never are sufficiently ill to consult a physician and may continue to spread their germs throughout their lifetimes.

If we were still dependent upon the old methods of detecting tuberculosis in the human body, namely, by the presence of symptoms and abnormal physical signs, the future of tuberculosis control would be grave, indeed. Modern diagnostic methods leave the medical profession with no excuse whatso-



ever for permitting tuberculosis to cause illness or to even become communicable in the vast majority of cases, provided our educational program convinces everyone in a family that an initial examination and periodic examinations thereafter, are indicated.

The first step in every examination for tuberculosis consists of the administration of the tuberculin test. The result of using tuberculin as testing material relegates to the discard all arguments against it. When properly administered, the tuberculin test provides us with information which cannot possibly be obtained in any other manner. Within three to seven weeks after tubercle bacilli have entered the body and have found lodgment in the tissues, the areas of disease which they produce are still microscopic in size, yet this test reflects their presence. Usually it is years before the body is incapacitated in any manner whatsoever, and a long time before any other phase of the examination will reveal, with certainty, the presence of tuberculosis. The test immediately indicates two significant facts: first, that the positive reactor has been exposed directly or indirectly to a person with communicable tuberculosis; second, that the germs have entered the body and have set up foci of disease. Every human body, regardless of age, race, etc., has an effective defense mechanism against the first attack of the germs of tuberculosis; so effective, in fact, that the bacilli are quickly walled off within the tissues. However, the defense mechanism is not capable of destroying them, and since tubercle bacilli, although completely walled off, have the ability to live over long periods of time, the tuberculin test continues positive, as long as they live.

The walls which imprison the tubercle bacilli may be broken by trauma or they may actually be resorbed, thus setting free the germs which have for a long time been imprisoned. Fortunately, this does not always occur; indeed, in a majority who become infected with tubercle bacilli it never occurs. Inasmuch as it is always a possibility and actually occurs in a minority group, a positive tuberculin reaction indicates a definite threat to the reactor. A positive tuberculin reaction does not mean, as many would like to believe, that at some time the body has been infected,

but such infection was of no significance because no illness appeared. It does mean that the body at some previous time has been infected and that there are still living tubercle bacilli present. The test indicates that every positive reactor should be carefully examined for the destructive type of disease since only those who react positively to the tuberculin test either have already developed or at some subsequent time will develop a reinfection destructive type of tuberculosis.

Tuberculosis among positive tuberculin reactors may make its appearance in any one of many parts of the body, such as the bones, joints and kidneys, but the most common site is the lungs. Moreover, tuberculosis of the lungs is more likely to be spread to other persons than that in any other location because of the direct communication with the involved area through the medium of the sputum. In the early stages of development, areas of disease in the lungs do not produce any physical signs which can be detected by the examination even with the stethoscope from the surface of the chest. As soon as an area of disease reaches such a size as to cast a shadow which can be visualized on the x-ray film, the location of the disease in the lung can be determined by x-ray examination. This usually is two or three years before symptoms and abnormal physical signs make their appearance. Therefore, an x-ray film examination should be made of the chest of every person who reacts positively to the tuberculin test. The majority of these reactors will reveal no evidence of significant disease on the first x-ray examination, but one examination is not enough. In fact, all such persons should have an annual examination as long as they live. While it is true that the majority will go through life without developing any evidence of clinical tuberculosis, it is also true that there is a significant minority who at some time will present definite evidence of disease. The secret lies in detecting this disease before it has caused much destruction, at which time it usually can be treated successfully with little expense to the individual or the community and with little loss of time to the individual. Inasmuch as we have no way of determining which persons who react positively to the tuberculin test will later develop clinical disease,

we must examine all annually in order to detect, at the opportune time, the minority group with disease.

It is unfortunate, indeed, that shadows cast on x-ray film are not diagnostic; that is, shadows cast by tuberculous disease may appear the same as those produced by other pathologic conditions which develop in the lung. Moreover, the person with a positive tuberculin reaction is just as likely to develop these other non-tuberculous areas of disease as the person who reacts negatively to the test; therefore, all the information the original x-ray film shows is that an area of disease of some kind is present. Nevertheless, etiological diagnoses of shadows without other phases of the examination are made. Such diagnoses are never justified when other phases of the examination will determine, with accuracy, the nature of the disease casting the shadow.

The clinician must now complete the examination. He will immediately send to the laboratory any sputum which is coughed from the lungs or even cleared from the throat to be examined not only for tubercle bacilli but for other organisms which cause disease in the lungs. If the report is negative, examination of the gastric contents may reveal tubercle bacilli. The differential leukocyte counts and red-cell sedimentation tests, not once but over a period of weeks, may be helpful. Persons who are in the "cancer age" may require bronchoscopic examination and biopsy. Again, bronchoscopy may lead to the finding of an unsuspected foreign body with sufficient reaction around it to cast the shadow on the x-ray film or it may show the presence of some obstruction, such as a mucous plug, in a bronchial ramification resulting in atelectasis. This phase of the examination is now performed with such skill that even pulmonary tuberculosis is not a contraindication to its use. In some cases after all of these phases of examination have been performed the etiology of the disease may be undetermined. Serial x-ray films, that is, films made every few weeks to determine any changes that occur in the shadows, may be necessary. Some shadows will completely disappear in a short period of time. They are often due to unresolved pneumonia. Other shadows will remain unchanged over a long period of time and may

represent disease that is completely under control when it was first detected. Still other shadows will gradually increase in size and may even show evidence of beginning cavity formation. These often are due to progressive pulmonary tuberculosis. The values of the x-ray are: first, in detecting the location of an area of disease; second, in observing any changes that occur over a period of time in those whose etiology cannot be determined by the usual methods.

The fact has now been well established that tuberculosis in communicable form rarely develops in the human body before the period of adolescence. While it is true that children become infected with tubercle bacilli and react positively to the tuberculin test, and some develop extrapulmonary lesions such as those of the bones and joints, very few of them present chronic pulmonary disease. It has also been well established that the child with only the first infection type of tuberculosis does not require institutional care; therefore, the omission of a unit in the sanatorium for such children is in accord with the latest scientific reports. It is far better to remove from the home and the community the patient with contagious tuberculosis than to remove the children who are safe associates and who do not require institutional care.

While we are active in the educational program that will entail an adequate examination of all persons for tuberculosis, there are certain groups which should be examined at once. Among them is the group employed in our schools, both private and public. This is not because the teachers and other school employees have more tuberculosis or a different type of disease than those in other professions and occupations, but because they have intimate association with the children as well as many of the adults in the community where they work. In a number of carefully conducted surveys, unmistakable cases of tuberculosis have been found among the teachers and other employees of the school system.

No one knows better than you that a considerable number of tuberculous patients migrate to this state, thus complicating your problem from the standpoint of the spread of tuberculosis. If some provision could be made whereby all of these persons would come un-



der the care of physicians well qualified to treat and prevent tuberculosis, the problem would not be serious. Unfortunately, many who seek relief through change of climate and who after arriving do not come under the care of physicians have communicable disease and, therefore, spread their tubercle bacilli. The solution of this problem is difficult; the veterinarians finally had to solve it as far as cattle were concerned by setting up quarantine at certain state and county lines.

In the management of the patients found to have tuberculosis who are not cared for by the sanatorium and the discharged patient, the physicians practicing medicine in this state are the most important. I am sure that no one is more aware of this fact than the members of your State Tuberculosis Board and Doctor Thompson. If all physicians who are not now taking an active part in the campaign against tuberculosis could be enlisted in this work, you would immediately have approximately 1800 workers. Even those in specialties distinct from tuberculosis have a role to play. For example, the oculist can administer the tuberculin test to every person who reports to him for examination or treatment of an eye condition and those found to react positively can be referred for the remaining phases of a complete examination. Again diagnosticians can refer those with demonstrable disease to general practitioners and therapists. Because the physicians are scattered throughout the state they are accessible to all. There is also a fine nursing profession in this state from which hundreds of workers can be recruited. If the State Department of Health, the State Tuberculosis and Health Association, and the State Tuberculosis Board will put in the field only enough physicians and nurses to go about the state with the very latest information on diagnosis, treatment, and prevention, and disseminate it to the physicians and leave them fully equipped to continue the work in their individual offices and communities, an important step will be taken toward the control of the disease.

Many cases of tuberculosis can be treated

successfully by local physicians, but no patient with communicable disease which cannot quickly be rendered non-communicable should be allowed to continue to spread the germs to others. All such persons should be hospitalized not only for their own good but also for that of their communities. Every state should provide an adequate number of beds to accommodate all such tuberculous patients. Last year approximately 1000 persons died in Florida from tuberculosis. Probably all of those who died of disease of the lungs were spreaders of tubercle bacilli in their homes and communities. In addition to those who died, a great many more were ill with the disease in communicable form. The 312 beds of this sanatorium will seem small and inadequate to solve the problem of hospitalization of communicable cases, but since a single person with communicable tuberculosis is capable of eliminating from the body between thirty and forty million tubercle bacilli every day, the value of your work is apparent.

The announcement of the building and opening of this sanatorium has been spread widely over the state, and this in itself has increased the interest of the citizens in tuberculosis. This increased interest and the information that the disease is contagious and communicable cases should be hospitalized, no doubt will facilitate the control program and the problem of making more beds available either here or elsewhere. As time passes, the need for more sanatorium beds can be determined and it is quite possible that other institutions similar to this will be found necessary. It is gratifying to know that you have divided the state into five tuberculosis districts with an institution in each of them ultimately. Provision for the isolation of communicable cases could be made in every district of the state by using the general hospitals. Admission of the more advanced cases to such units for whom treatment has little to offer but for whom isolation is essential would protect the homes and the communities. This would relieve the pressure on the State Sanatorium and permit the su-



perintendent to admit patients for whom treatment is indicated.

The second objective of the sanatorium is to add everything possible to the comfort and cheerfulness of the patient, prolong life, and restore as many as possible to a noncommunicable stage of the disease and good working capacities. It must be made clear at the outset of any sanatorium program that not all patients admitted will recover, since approximately 80 per cent of them have lost their best chances of recovery before they are admitted to the sanatorium regardless of the expertness of the staff or the equipment of the institution. The sanatorium superintendent and staff who can make the institution such a desirable place to be that such patients are willing to remain as long as they live must be credited with success in this field. A library is an essential part of the sanatorium for the tuberculous, and, when it is in charge of a well-trained librarian, it is an important factor in the treatment of the patient because it provides him with information which he has long desired but in the numerous activities of normal life has not found time to obtain. Not infrequently one hears an ex-sanatorium patient state that the time spent in the institution was not wasted by any means, for it provided an opportunity for reading which probably otherwise would never have come to him. In the re-education program, which has become an important part of the modern sanatorium, the library plays an important role. Those persons who are admitted to this institution with the disease in a stage amenable to treatment will have as good chance of making recovery as is available any place in the nation.

Time was when sanatorium patients were put to bed and for those who were making good recoveries, no thought was had of their future activities, although some were actually told that they must never return to their previous work because of its hazardous nature. This left them in mid-air at the time of dis-

charge from the institution. The modern sanatorium provides for re-education and rehabilitation, much of which can be carried on to great advantage while the patient is still on treatment. If the patient's previous occupation is contraindicated, he may be re-educated so that by the time he leaves the institution he is qualified to enter upon a new field of work. Doctor Thompson's plans for re-educating and rehabilitating the patients who make good recoveries in this sanatorium are excellent. Among other activities, I was particularly impressed with his plan to use some of the land of this institution for the growing of citrus fruits, primarily for the purpose of teaching patients this industry.

All the factors necessary for the treatment of tuberculosis are thoroughly understood and have been extensively practiced by the medical personnel of this sanatorium. This institution, therefore, is equipped in every way to administer most modern treatment including the latest surgical procedures. The nursing staff is of great importance. The dietitians, the cooks, the orderlies, in fact, everyone employed in this institution has a significant role to perform in contributing to the happiness and well-being of the patients, and, thus, win and maintain confidence in and respect for the sanatorium in the minds of the citizens of Florida.

When tuberculosis has been brought under control so that it is no longer more than a minor disease problem and the final history is written, the sanatorium must be given one of the most prominent places. The sanatorium more than any other factor controllable by man is responsible for the reduction in the spread of tuberculosis among human beings. In fact, through the sanatorium the incidence of tuberculosis among children and young adults has been decreased so that we can now see the ultimate solution of the problem.

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*91 South Seventh Street.*

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(Terms expire after A.M.A. meeting, 1939)

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**NATIONAL HEALTH CONFERENCE**

Announcement was made last May that a conference would be called by the Federal Interdepartmental Committee to coordinate health and welfare activities. Dr. Olin West, secretary of the American Medical Association, with the approval of the Board of Trustees, invited the chairman of that committee, Miss Josephine Roche, to meet with the House of Delegates of the American Medical Association at San Francisco. Miss Roche was not able to attend, but her message was read by Dr. Warren F. Draper of the U. S. Public Health Service. The statement made at that time was published in the A. M. A. Journal of July 2, page 52. In this message from Miss Roche to the House of Delegates, attention was called to the fact that the National Health Conference was suggested by President Roosevelt who urged the Interdepartmental Committee to invite representatives of the interested public and of the medical and other professions to examine the health problems and discuss how to deal with them.

The National Health Conference met in Washington, D. C., July 18, 19 and 20. A Technical Committee on Medical Care to the Interdepartmental Committee to Coordinate Health and Welfare Activities made a report

to the President on February 14, 1938, which included:

1. Preventive health services for the nation as a whole are grossly insufficient.
2. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and for professional services in hospitals is both insufficient and precarious, especially for services to people who cannot pay the costs of the care they need.
3. One-third of the population, including persons with or without income, is receiving inadequate or no medical service.
4. An even larger fraction of the population suffers from economic burdens created by illness.

Five recommendations were submitted:

1. Expansion of public health and maternal and child health services.
2. Expansion of hospital facilities.
3. Medical care for the medically needy.
4. A general program of medical care.
5. Insurance against loss of wages during sickness.

The cost to federal, state and local governments on an annual basis is estimated at approximately \$850,000,000. A very complete and carefully written report of this National Health Conference will be found in the A. M. A. Journal of July 30 on page 432. Editorials from a number of leading newspapers, on the National Health Conference, were printed in the A. M. A. Journal of August 6, pages 540-542. The editorials reproduced are as follows:

"The Builders of the House," *The Evening Star*, Washington, D. C., July 20.

"A Monopoly in Medicine," *Evening Public Ledger*, Philadelphia, July 20.

"The Health Conference," *The New York Times*, July 19.

"Medical Paternalism," *The Indianapolis Star*, July 21.

"Government and Medicine," *The Evening Star*, Washington, D. C., July 26.

"The Problem of Health," *The New York Times*, July 25.

"Consideration of Another Step on the Way to State Socialization," *Arizona Republic*, Phoenix, July 22.

An editorial appeared recently in a Jacksonville paper and is reproduced as follows:

**NATIONAL HEALTH CONFERENCE**

*Florida Times-Union, Jacksonville, August 3, 1938.*

"The health problems of the nation—like its economic problems—are appallingly complex," says the New York Herald Tribune. "They cannot be answered by any such simple formula as health insurance. But they must be faced, studied and, in the course of the years, solved."



The newspaper, however, believes that it is an excellent sign of progress that the National Health Conference at Washington showed a refreshing open-mindedness toward the difficulties confronting it and a readiness to discuss every possible approach toward action.

It is found that the program brought forward by the technical committee seemed to provide a useful basis for debate even though its scale was rather "hifaluten; up in the air," so to speak. The proposition that an additional annual expenditure of \$850,000,000 by Federal, State and local governments—additional to what they are now spending; for health; was directly in line with the ideas of the day—huge spendings, for anything and everything. Spending of public money in volume and in all directions.

The Herald Tribune finds that the aims set forth by the Conference committee are admirable. It is sure that health services are quite inadequate, insufficient. "Hospital facilities are lacking in many rural regions and the 'medically needy' are far from being well cared for despite the endless amount of time that the doctors and surgeons of the nation donate to their care," it says. "An expansion of the maternal and child health services is urgently needed. The report shows a wise open-mindedness as between direct grants out of taxation and specific insurance contributions."

But it is declared that a great mistake would be made if the suggestions of the conference committee were at once put into operation. The political aspect of such a gigantic undertaking would alienate a large portion of the voters. So also, would be the reaction if the excessive expansion of Federal agencies were set up as suggested. There is need, it is thought, for patient evolutionary progress, in the States, with the Federal Government leading and advising—but not directing.

But in such a gradual advance the co-operation of the mass of medical men is absolutely essential, the Herald Tribune believes. "Nor can we believe," it says, "that their aid will be withheld from any fair and reasonable approach." Then adds:

The socialization of the doctor and the regimentation of the patient which some enthusiasts lately advocated have been rejected by the good sense of social worker and medical scientist alike. Judging by the broad-minded attitude displayed at the Washington conference—under the effective leadership of Miss Josephine Roche and Dr. Parran—we think the path lies open for a fresh approach in which every qualified element of expert opinion would participate. We hope the medical profession will find a way to play its essential part—assume, indeed, the leadership which is its right—in this great task. The greatest and the least of doctors have always given freely of their time and skill to serve those who could not afford to pay. Prevention is the goal of every intelligent physician. No new motive, no new principle is needed. The call is simply for the reorganization of an old generosity and an old loyalty, so that a nation of 120,000,000, with untold riches of modern science, may be served as efficiently and humanely as was the small community by its devoted general practitioners in more primitive days.

It would seem better, before regimenting the patients and socializing medicine, that some comparisons be made regarding the health and enjoyment of life in the United States and Russia, perhaps, or Italy or Germany. That statement (no doubt backed up by figures) which is being argued that there are American citizens living in sections where doctors are scarce and surgeons and hospitals are not next or across the road is not so terrible. This was the case when the country was young.

Today, in the age of telephones and automobiles and rapid transit by rail, boat and air, no one needing medical or surgical attention is very far from help. Incidentally there is an automobile to every five people, or less, in the yard, the garage or nearby; and they are all available for help in emergency. That stuff about

many people needing medical or surgical attention being deprived of it through the absence of physicians in the vicinity is not anything to worry about. It would be too bad to build a hospital at every crossroad—and if it was done the greater part of the sick who needed special service would go to Baltimore, or Rochester, or New York to get it.

And as for the poor people suffering because they cannot afford to visit the doctor, there's little of it. The poor people have medical care as well as help in this country. The records will show that few indeed are the people who suffer from neglect when ill.

## SPECIAL SESSION OF A. M. A. HOUSE OF DELEGATES

As this Journal goes to press an announcement has just been received that the House of Delegates of the American Medical Association will hold a called meeting at the Palmer House in Chicago, September 16. The business to be transacted at this special session will be limited to the consideration of the national health program submitted to the National Health Conference recently held in Washington and to such other matters as may be submitted to the House of Delegates by the Board of Trustees.

A special meeting of the Executive Committee was called by Dr. Gilbert Osincup, the chairman, for September 14 at Ponte Vedra. The two delegates from Florida, Dr. Meredith Mallory and Dr. Herbert Bryans, were invited to attend this Executive Committee meeting. From this Jacksonville meeting the Association's two delegates were to go direct to Chicago.

\* \* \*

## STUDY OF NEED AND SUPPLY OF MEDICAL CARE

The first county society in Florida to forward summary sheets for county medical societies in connection with the American Medical Association's study of need and supply of medical care was the Broward County Medical Society whose report was sent through its secretary, Dr. O. C. Brown of Ft. Lauderdale. The Broward County Medical Society is to be congratulated on its promptness in working up the necessary information in connection with this survey. In recent numbers of the A. M. A. Journal will be found information sent from other county societies in the United States. Officers of our county medical societies will be interested in reading in detail this information, as a guide in preparing their material for presentation.

## A DOCTOR'S TRUST?

An editorial under this title appeared recently in a Jacksonville paper, commenting on proceedings against the American Medical Association, the Medical Society of the District of Columbia and officials of both organizations. In order that the readers of this Journal may have an opportunity to review this editorial, it is reproduced here:

*Jacksonville Journal, Jacksonville, Florida,  
August 13, 1938*

The department of justice is preparing to begin grand jury proceedings against the American Medical Association, the Medical Society of the District of Columbia and officials of both organizations under the anti-trust laws. The reason for the prospective prosecution is the two medical organizations' opposition to an enterprise styling itself Group Health Association, Inc., described as a co-operative organized by government employees to provide prepaid medical care. The co-operative collects fees from its members regularly and retains physicians to attend them when they are ill.

In announcing that he was initiating a grand jury inquiry into the medical associations' hostility toward the government employees' co-operative, Thurman W. Arnold, assistant attorney general, asserted that physicians participating in the co-operative had been threatened with expulsion from the district medical society; that other physicians had been warned not to call the participating doctors in consultation, and that the co-operative's physicians were being excluded from Washington's hospitals.

We are not in a position to pass judgment on the merits of the controversy between the Medical Society of the District of Columbia and the Group Health Association, Inc., because Mr. Arnold has given only one side of the question; and the Washington physicians have maintained a professional silence thus far. But, in his own ex parte statement, Mr. Arnold convicts himself of twisting the anti-trust laws into something which Congress never had in mind when enacting them.

The Medical Society of the District of Columbia and the American Medical Association are voluntary professional organizations. No physician is obliged to join either; and no physician can be barred from practice for non-membership. Like all voluntary professional organizations, these medical societies have a right to pass on the qualifications of members and the desirability of prospective members. If an individual physician feels that he has suffered damage to his practice by unjustified exclusion from one or both organizations involved, he has recourse in ordinary civil law. But, by no honest interpretation of the anti-trust laws can the government resort to criminal prosecution to force a medical society to admit to membership or to retain on its rolls any physician who identifies himself with an enterprise which the society—rightly or wrongly—deems unprofessional or unethical.

If the department of justice can invoke the anti-trust laws against the American Medical Association and the Medical Society of the District of Columbia for their opposition to the Washington co-operative, then it can institute similar proceedings against any bar association which excludes from membership lawyers who associate themselves with enterprises condemned by a majority of their colleagues.

If the department of justice can invoke the anti-trust laws against the Washington physicians, it can invoke them against the national organization of college professors which blacklisted the late Huey Long's state university and other institutions accused of practices disapproved by the professors.

## THE ROENTGENOLOGIST, THE PATHOLOGIST AND THE ANESTHETIST, UNDER HOSPITAL INSURANCE PLANS

One of the most significant actions taken by the House of Delegates in San Francisco concerned the relationship of three professional groups—roentgenologists, pathologists, anesthetists—to various hospital insurance plans. Several resolutions which were offered from various sections of the country were considered by the Council on Medical Education and Hospitals. The Council in its report said:

"The proposers of these resolutions, the delegates from the Massachusetts Medical Society, members of the California Medical Association and others met with the Council to express their views concerning the problems that concern the practice of medicine in hospitals by radiologists, pathologists and anesthetists. These problems have been rendered more acute by the rapid extension of systems of group hospital insurance within the last few years. The Council believes that these problems are of vital concern to the medical profession; that unwise decisions at this time may lead to consequences that would be disastrous to physicians and to the public alike, and that, therefore, a serious study should be made of existing relationships between hospitals and the physicians practicing therein, especially in the departments of anesthesia, radiology, pathology and physical therapy, with a view to standardizing the relationship of these services to the hospital and, where necessary, of reaffirming the principles of ethics involved.

"The Council recommends that it, jointly with the Bureau of Medical Economics, be authorized to undertake these studies and to confer with other interested agencies, in order that it may be in a position to establish ethical standards for the practice of medicine by phy-



sicians holding positions in hospitals and to prevent the exploitation of either the public or the profession. If during this study it is revealed that hospitals registered and approved by the Council are exploiting the public or the profession, such approval may be revoked."

This report of the Council on Medical Education and Hospitals was adopted by the House of Delegates of the American Medical Association. Therefore, during the coming year a suitable study will be made and recommendations no doubt will be drawn up for submission to the House of Delegates at the next annual session.

The above appeared in an editorial on page 158 of the July 9 Journal of the American Medical Association. Anyone interested in this subject is urged to read the entire editorial appearing in that Journal.

## FLORIDA EXAMINING BOARD REQUIRES CITIZENSHIP

Because of the influx of medical practitioners into the United States, the House of Delegates of the American Medical Association, in session recently in San Francisco, saw fit to pass a resolution recommending to the various boards of medical examiners that they consider seriously the need for adopting rules requiring that each applicant for license hold full citizenship in the United States.

The resolution is reproduced in full, together with a letter from Dr. William M. Rowlett, secretary of the State Board of Medical Examiners, in which he points out that Florida was one of the first—if not *the* first—to adopt such a rule for the protection of the doctors in this state.

WHEREAS, The license to practice medicine and surgery in many countries is limited strictly to citizens of these countries; and

WHEREAS, In addition to holding full citizenship, each applicant is required in several of these countries to show that his medical education was pursued and completed in said countries; and

WHEREAS, Many foreign graduates in medicine and surgery in increasing numbers are seeking admittance to the practice of medicine in these United States; and

WHEREAS, In order to convey adequately to these applicants a full and satisfactory knowledge of the American conception of patriotism and of ethical ideals in medicine, it is necessary that a period of residence be required; therefore be it

*Resolved*, That in addition to the requirements for foreign graduates, as outlined in a resolution adopted by the House of Delegates for the American Medical Association in 1936, it is highly desirable that an ad-

ditional requirement of full citizenship in the United States of America be demanded; and be it further

*Resolved*, That the House of Delegates of the American Medical Association approve the foregoing and that a copy be sent to the properly constituted officers of each examining board of the United States and to the Federation of State Medical Boards, with the request that they consider seriously urgent need for the adoption of such rules and/or legislation necessary to put the purposes of these resolutions into effect.

## STATE BOARD OF MEDICAL EXAMINERS OF FLORIDA

Tampa, Florida  
August 18, 1938

DR. SHALER RICHARDSON, Editor  
Florida Medical Journal  
Jacksonville, Florida

Dear Doctor Richardson:

Your letter of the eleventh read with a great deal of interest. Am well acquainted with the resolutions adopted by the House of Delegates of the American Medical Association at the San Francisco meeting. The activity of the members of the Florida Medical Association, I feel, to some extent is responsible for these resolutions although we received no credit.

For years the foreign graduate has been a difficult problem with the Board of Medical Examiners. As you are aware, our Medical Practice Act only requires these foreign physicians to declare their intention of becoming American citizens in order to be eligible to appear before the Board. In recent years the influx of these physicians has been so great that in 1935 I made a personal survey of the medical colleges in Cuba, South America, England and Europe. To my amazement I found many of these colleges which we had held in high esteem were nothing more than diploma mills. In practically all of the Latin Universities, including the University of Paris, they were issuing to their graduates two different types of diplomas; one with a seal of merit that made its possessor eligible to be licensed to practice in that particular country, the other was merely an honorary degree of M.D. that would not permit its possessor to practice in the country in which it was issued, this latter diploma being ostensibly for social recognition. However, with the latter type of degree in his possession the graduate would come to this country and enter the practice of medicine. During my survey I observed many young Americans taking advantage of this situation to gain their medical degree after being denied admission to our American colleges. I also found in addition to these legalized diploma mills that students who failed in the higher grade institutions would enter another institution and continue their studies.

The situation was rather appalling and upon my return to America I made a report to the Federation of State Boards and to many of the State Board Officers with whom I was intimately acquainted. At the same time the Florida Board of Medical Examiners adopted the following resolutions: "Foreign physicians must prove that they are citizens of the United States by producing their citizenship papers. Physicians graduating from foreign colleges must take and receive credits for a senior year's work in a Class "A" American college before being eligible to appear before the Florida Board." This was followed, to some extent, by a number of the other state boards.

I am glad that we have the honor to be the first state to take steps to curb the trek of these poorly educated foreign physicians to our Country.

With my ever good wishes to you, I am yours,

Most sincerely,

(Signed) W. M. ROWLETT, M.D.,  
Secretary.



## MEDICAL LICENSES GRANTED

The Secretary of the Florida State Board of Medical Examiners, Dr. W. M. Rowlett, reports that at the last medical examination held in Jacksonville, June 13-14, ninety-seven of the one hundred and twenty-three applicants who took the written examination passed. There were twenty-six failures. Nearly every college in the United States was represented. There were three women and two negroes among the applicants. The following doctors were successful:

Adams, John Powell—Panama City, Tulane, 1938.  
 Annis, Edward Roland—Care John L. Graham, Asst. Attorney Genl., Tallahassee, Marquette, 1938.  
 Armstrong, Edward Sheehan—2240 McDowell St., Augusta, Ga., Georgia, 1932.  
 Bancroft, Josiah Dozier—201 N. 77th St., Birmingham, Ala., Tulane, 1931.  
 Bennett, Bruce H.—Fort Pierce, George Washington, 1938.  
 Berman, Harry—1519 W. Warren St., Chicago, Ill. Illinois, 1933.  
 Brown, Edwin Henry—Duval County Hospital, Jacksonville, Vanderbilt, 1937.  
 Campbell, Elmer Bernard—Veterans Administration, Milwaukee, Wisc., Emory, 1923.  
 Canipelli, Edward—Henry Ford Hospital, Detroit, Michigan, Emory, 1934.  
 Carroll, Edward Joseph, Jr.—6945 McPherson Blvd., Pittsburgh, Pa., Pittsburgh, 1934.  
 Chunn, Charles Francis—1505 Delaware St., Detroit, Mich., Duke, 1935.  
 Clements, Merritt Ryals—Duval County Hospital, Jacksonville, Emory, 1935.  
 Cogan, James Richard—2034 N. W. 18th St., Miami, Harvard, 1935.  
 Conley, John J. St. P.—313 Rowland Ave., Carnegie, Pa., Pittsburgh, 1937.  
 Cooper, Sam Marshall—Jackson Memorial Hospital, Miami, Tennessee, 1937.  
 Crisler, George Russell—317 Medical Arts Bldg., Charleston, W. Va., Rush, 1931.  
 Crowell, James Allen—Care Mrs. W. W. Hendricks, Hibiscus Park, Gainesville, Louisiana, 1938.  
 Delano, Percy Joseph—40 E. Oak St., Chicago, Ill., Illinois, 1927.  
 Duncan, George Walton—Vanderbilt University Hospital, Nashville, Tenn., Emory, 1938.  
 Ebersbach, Rosalind—3105 El Prado Blvd., Tampa, Michigan, 1936.  
 Ekermeier, Ernest Wolfert—Ohio Soldier's & Sailor's Orphan's Home, Zenia, Ohio, Cincinnati College of Medicine, 1931.  
 Emerson, George Oliver, Jr.—St. Luke's Hospital, Jacksonville, Virginia, 1937.

Essrig, Irving Martin—Touro Infirmary, New Orleans, La., Tulane, 1938.  
 Foltz, Louis Michael—Care F. C. Hauser, 226 Wallace Ave., Covington, Ky., Cincinnati Eclectic, 1937.  
 Frehling, Stanley—1810 Bardstown Road, Louisville, Ky., Louisville, 1933.  
 Fulton, Morris Crawford—University Hospital, Augusta, Ga., Georgia, 1936.  
 Funkenstein, Dan Hertz—Terrace Apartments, Macon, Ga., Tulane, 1934.  
 Garner, John Robert—St. Thomas Hospital, Nashville, Tenn., Louisville, 1932.  
 Glenn, Francis William—600 E. Cheltenham Ave., Germantown, Philadelphia, Pa., Temple, 1933.  
 Goren, Morris Leon—2121 S. Harding Ave., Chicago, Ill., Northwestern, 1936.  
 Gray, Charles McCurdy—American University, Washington, D. C., Johns Hopkins, 1930.  
 Hallson, Daniel Collin McKenzie—Petersburg Hospital, Petersburg, Va., Manitoba, 1932.  
 Halpern, Sidney—Jackson Memorial Hospital, Miami, Jefferson, 1937.  
 Hain, Oscar Emerson—834 Briarcliff Road, Apt. 7, Atlanta, Ga., Emory, 1938.  
 Hamff, Leonard Harvey—University Hospital, Ann Arbor, Michigan, Emory, 1938.  
 Hibbard, Rodger James Blanchard—State Sanatorium, Box 1118, Orlando, McGill, 1924.  
 Hipke, Lucius Warrington—425 E. Wisconsin Ave., Milwaukee, Wisc., Western Reserve, 1921.  
 Hollender, Abraham Risel—30 N. Michigan Ave., Chicago, Illinois, Illinois, 1915.  
 Holloway, Paul Dickson—U. S. Marine Hospital, Key West, Tulane, 1919.  
 Jares, John James, Jr.—Morrell Memorial Hospital, Lakeland, Rochester, 1935.  
 Jennings, Lloyd Harlan—1431 Hubbard St., Jacksonville, Iowa, 1937.  
 Jones, John Allen, Jr.—410 3rd Ave., Opelika, Ala., Emory, 1938.  
 Kendrick, Marvin Hayne—Luverne, Ala., Harvard, 1935.  
 Kent, James Marvin—Hillman Hospital, Birmingham, Ala., Rush, 1937.  
 Kuckku, Morris Edward—Dade County Hospital, Miami, Northwestern, 1937.  
 Laramore, Herbert Franklyn—Livingston, Texas, Texas, 1927.  
 Larsen, Carl John—Florida Sanatorium & Hospital, Orlando, Medical Evangelists, 1928.  
 Mazel, Maurice Seymour—2801 Indian Creek Drive, Miami Beach, Northwestern, 1918.  
 McDowell, Harold Clyde—Venice, Jefferson, 1931.  
 McIntosh, Oscar William—1608 Jefferson St., Jacksonville (colored), Howard, 1935.

- McNay, Miller Ost—1505 Delaware, Detroit, Mich.,  
St. Louis, 1933.
- Mills, Roosevelt Flax (colored)—801 Kings Road,  
Jacksonville,  
Meharry, 1936.
- Moody, William Meier—2109 Clifton Ave., Cincinnati,  
Ohio,  
Cincinnati, 1937.
- Morse, George Wray—Duval County Hospital, Jacksonville,  
Virginia, 1936.
- Morton, Henry George—Duke Hospital, Durham, N. C.,  
Duke, 1937.
- Murphy, William Francis—St. Vincent's Hospital,  
Jacksonville,  
Tufts, 1935.
- Murray, Thomas Valicius—207 Parker St., Tampa,  
Temple, 1938.
- Panzer, Ralph Passel—Pensacola Hospital, Pensacola,  
Cincinnati, 1938.
- Patton, Samuel Ellsworth—142 Hines Terrace, Macon,  
Ga.,  
Georgia, 1937.
- Pearson, R(ufus) Judson, Jr.—500 Alhambra Circle,  
Coral Gables,  
Emory.
- Pieck, Virgil Homer—St. Francis Hospital, Miami  
Beach,  
Cincinnati, 1936.
- Pitman, James Fling—327 E. Duval St., Lake City,  
Atlanta P. & S. (now Emory) 1913.
- Ragan, Charles Julian—700 South 47th St., Birmingham,  
Ala.,  
Tulane, 1938.
- Rankin, Donald Thompson—Blackshear, Ga.,  
N. Y. Homeopathic Medical College & Flower  
Hosp., 1914.
- Robin, Milton—2903 North Kedzie Ave., Chicago, Ill.,  
Illinois, 1937.
- Scanlon, John Joseph—Orange General Hospital,  
Orlando,  
Creighton, 1935.
- Schmidt, Henry Louis, Jr.—2504 Helen Street,  
Augusta, Ga.,  
Georgia, 1935.
- Selden, Joseph Luther, Jr.—City Hospital, Mobile, Ala.,  
Louisville, 1936.
- Seltzer, Morris Bromo—423 Richmond Ave., Orlando,  
Toronto, 1937.
- Sharp, Lee—1106 Mallory St., Pensacola,  
Ohio, 1934.
- Smithy, Horace Gilbert, Jr.—Roper Hospital, Charleston,  
S. C.,  
Virginia, 1938.
- Steenrod, Emerson Joseph—Rochester, Minn.,  
Pittsburgh, 1933.
- Stepp, Lawrence Lorraine—Maple Manor, Valencia,  
Pa.,  
Pennsylvania, 1917.
- Sternberg, Jacob Charles—2280 S. W. 16th Court,  
Miami,  
Bellevue, 1924.
- Stockard, Cecil—209 16th Street N., Bradenton,  
Atlanta College P. & S. (now Emory) 1908.
- Tight, Alvin John—628 Gordon Ave., Thomasville, Ga.,  
St. Louis, 1936.
- Townsend, Frank Marion—Southern Baptist Hospital,  
New Orleans, La.,  
Tulane, 1938.
- Treadwell, Willard Vivian—601 W. Hickory St.,  
Arcadia,  
Tennessee, 1938.
- Wagner, Rudolph Theodore—112 Ann Street, Key West,  
New York Univ., 1936.
- Ward, Francis O'Berry—Macon Hospital, Macon, Ga.,  
Emory, 1938.
- Warren, Kenneth Wayne—Perry,  
Temple, 1938.
- Watters, Vernon Gregg, Jr.—Sebring,  
Iowa, 1938.
- Weaver, Oswald Massena—700 W. 10th St., Jacksonville,  
Virginia, 1936.
- White, Edward Timothy, Jr.—Charity Hospital, New  
Orleans, La.,  
Tulane, 1938.
- Wilkins, Walter Eugene—Vanderbilt Hospital, Nashville,  
Tenn.,  
Vanderbilt, 1938.
- Wilkinson, H(enry) Fielding—507 Herald Bldg.,  
Bellingham, Washington,  
Yale, 1921.
- Williams, Margaret Brinkerhott—Granada Apts.,  
Miami,  
Virginia, 1938.
- Williams, William—1234 Bryn Mawr Ave., Chicago,  
Ill.,  
Illinois, 1908.
- Wise, Robert Alexander—219 East 71st St., New York  
City,  
Columbia, 1925.
- Wood, George Oviatt—506 14th Ave., N. E.  
St. Petersburg,  
Vanderbilt, 1938.
- Wrenn, Simeon Mayo—Veterans Hospital, Bay Pines,  
South Carolina, 1930.
- Wright, Bernice Turner—Veterans Hospital, Bay  
Pines,  
Tennessee, 1927.
- Zborowski, Thomas Stanley—Riverside Hospital, Jacksonville,  
Georgetown, 1936.
- Zimmerman, Paul Arthur—Nashville General Hospital,  
Nashville, Tenn.,  
Vanderbilt, 1937.
- Zivitz, Nelson—164-03 89th Avenue, Jamaica, New  
York,  
Rush, 1934.
- Zola, Samuel—226 S. W. Miami Avenue, Miami,  
George Washington, 1936.
- Zucker, Milton Oswald—212 South Atlantic Ave.,  
Daytona Beach,  
Tufts, 1930.

---

## MEDICAL DISTRICT MEETINGS

Bradenton (D) . . . . .September 29, 1938  
Ft. Lauderdale (F) . . . . .October 13, 1938  
Gainesville (B) . . . . .October 27, 1938  
Eustis (E) . . . . .November 10, 1938

---

## STATE NEWS ITEMS

Dr. H. E. Winchester of Dunedin announces the removal of his offices to 241 Scotland Street.

\* \* \*

Dr. and Mrs. Harry A. Peyton of Jacksonville left on August 1 for a month's stay at Lake Eden, North Carolina.

\* \* \*

Dr. and Mrs. Warren Quillian and children of Coral Gables spent several weeks' vacation at their summer home in Junaluska, N. C. recently.

Dr. A. B. Johnson of Jamestown, New York, a member of the Florida Medical Association, left September 1 for Europe where he will spend three months in postgraduate study.

\* \* \*

Dr. and Mrs. Banks H. Goodale of Jacksonville accompanied by their two daughters, spent some time in North Carolina and Washington, D. C. during the month of August.

\* \* \*

Dr. Edward F. Fox of Miami has returned from a trip to Winston-Salem, N. C., Washington, D. C., and New York City. He also attended the National Phi Chi convention in Memphis, Tenn.

\* \* \*

Dr. Ralph Gowdy and family of Miami Beach recently returned from a delightful 10,000 mile automobile trip to the Pacific coast. They made the trip west over the southern route, then drove north to Seattle and back by way of Yellowstone Park.

\* \* \*

Dr. and Mrs. John D. Ferrara of Jacksonville have returned from a several weeks' stay in the North where Doctor Ferrara took postgraduate work at Harvard University.

\* \* \*

Dr. and Mrs. S. Marion Salley of Miami spent several weeks recently in and about Boston.

\* \* \*

Dr. T. M. Rivers of Kissimmee and Miss Amy Prouty of Putnam, Connecticut, were married at Putnam on August 22.

\* \* \*

Dr. William H. Kupper announces his removal from Starke to Miami Springs where he has opened offices in the Post Office Building.

\* \* \*

Dr. E. B. Hardee of Vero Beach announces that Dr. M. R. Clements has become associated with him in the practice of medicine and surgery with offices in the Redstone Building.

\* \* \*

Dr. and Mrs. Allan Jones and son, Allan, Jr., of Miami, left recently for Maplewood, N. J. While away, Doctor Jones will study in clinics in Boston and New York.

Dr. Raymond Sanderson of Jacksonville, colonel in the medical corps reserve of the U. S. Army has returned after spending two weeks as surgeon for Camp Shelby, the northern supply base for the Third Army maneuvers which were held in the DeSoto National Forest, Mississippi.

\* \* \*

The many friends of Dr. Lynn Whelchel of Miami will regret to learn of the recent death of his mother.

\* \* \*

Dr. Millard B. White's present address is Sarasota. Doctor White was formerly in Tampa but is now associated with Dr. Joseph Halton in the Halton Hospital, Sarasota. A new addition was erected to this hospital, with nine rooms and twenty-one beds. Doctor White's new quarters are very attractive and will make possible service to a much larger number of persons.

\* \* \*

Beginning October 19 and for thirty-six weeks thereafter the American Medical Association and the National Broadcasting Company will again unite in offering the American people the radio feature, Your Health. This radio program received the First Award in its classification from the ninth annual conference of the Institute for Education by Radio.

\* \* \*

Dr. Joseph B. Pomerance of Miami Beach has returned from a two-months' vacation which included visits to the East, the Middle West and Toronto, Canada.

\* \* \*

Dr. William H. McCullagh of Jacksonville announces the removal of his offices to Suite 609-611 Greenleaf Building. Doctor McCullagh limits his practice to neuropsychiatry.

\* \* \*

Dr. and Mrs. M. H. Tallman of Miami left August 6 for a month's vacation with Doctor Tallman's sister in Boise, Idaho.

\* \* \*

Dr. C. E. Tumlin of Miami has returned from a vacation spent with his family in Brevard, N. C.



Dr. Nathan S. Rubin of Pensacola has returned from a vacation trip in the North. In addition to taking a postgraduate course in ophthalmology at Strong Memorial Hospital in Rochester, New York, Doctor Rubin visited clinics in New York City and Pittsburgh.

\* \* \*

Dr. and Mrs. W. L. Fitzgerald and children of Miami spent their vacation in the mountains of Virginia. They also visited in Washington, D. C.

\* \* \*

Dr. W. E. Mitchell of Bushnell, secretary of the Sumter County Medical Society, died at a hospital in Atlanta on August 24. He is survived by his widow and three daughters, Margaret of Atlanta; Nelletta and Joyce of Coleman, Florida; and a sister, Miss Lizzie Hyde of Nocatee, Florida.

#### GEORGE O. DAVIS

The following testimonial was passed by the Suwannee County Medical Society in the recent death of Dr. George O. Davis:

"On July 6, 1938, Doctor George O. Davis of Madison, Florida, passed from this life. In the passing of Doctor Davis, the medical profession has suffered a distinct loss. This is particularly true of the north Florida section where Doctor Davis made his home and where his enthusiastic efforts in the relief of human suffering were a definite stimulus to his fellow practitioners of medicine. Doctor Davis was particularly interested in the study and treatment of malaria and hookworm disease, and while active in all channels claiming the attention of the general practitioner, he gave untiringly of his time and thought in helping those afflicted with these two devastating diseases.

"He was one of the founders and active supporters of the Suwannee River Medical Society and we shall miss his genial personality and wise counsel. In our own sorrow we wish to extend our heartfelt sympathy to the bereaved family."

#### MAX GHERTLER

Dr. Max Gherbler of Miami, who died May 11, 1938, was born in the city of Jawsy, Rumania in 1868. In 1895 he graduated from the New York University, after which he served at the French Hospital and also at the Italian Hospital in New York. For many years he was diagnostician for the New York Board of Health.

Doctor Gherbler came to Florida in 1924, locating in Miami, where he has since practiced. He was an extensive traveler, both for study and pleasure. His postgraduate work included courses at Vienna and Germany and his pleasure trips took him to many parts of the world.

His scientific and fraternal affiliations included the American Medical Association, the Florida Medical Association, Dade County Medical Society, the Masonic Order, and the Elks.

#### HENRY GATRELL

Dr. Henry Gatrell of Fairfield died on July 24, 1938. Born in Campbell County, Kentucky, June 21, 1874, he attended the Ohio State University and the medical school of Tulane University, securing his M. D. degree from the latter in 1898. He was licensed in Florida the same year and has for the past forty years practiced his profession in Marion County.

Doctor Gatrell was a member and past vice-president of the Marion County Medical Society, a member of the Florida Medical Association and the American Medical Association.

#### COMPONENT COUNTY SOCIETIES

##### BAY COUNTY MEDICAL SOCIETY

THE BAY COUNTY MEDICAL SOCIETY HAS BECOME THE FIFTEENTH COMPONENT UNIT TO REPORT 100% OF 1938 MEMBERSHIP DUES. A GREAT DEAL OF CREDIT MUST GO TO THE FOLLOWING OFFICERS FOR THE SPLENDID SHOWING OF THIS SOCIETY: W. J. BLACKSHEAR, PRESIDENT; DONALD S. FRASER, VICE-PRESIDENT; AND W. C. ROBERTS, SECRETARY-TREASURER.

## DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held September 6 at the Ingraham Building, the following program was given:

"Jellyfish and Portuguese Man-of-War Stings"—E. J. Thomas, Miami.

Discussion—Wiley Sams and Frank Voris.

"Common Foot Ailments"—E. W. Cullipher, Miami.

Discussion—F. A. Vogt and Harrison A. Walker.

\* \* \*

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON  
COUNTY MEDICAL SOCIETY

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held at Wakulla Springs, Thursday, August 18, at 3 p. m. The following papers constituted the scientific program: "The Chronic Cough"—R. C. Pindergrass, Americus, Ga.

"Malaria"—Mark Boyd, Tallahassee.

"Tuberculin Tests"—A. J. Logie, Jacksonville.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

At the meeting of the Pinellas County Medical Society held on the evening of August 5, Dr. C. S. Franckle was principal speaker. He presented a paper on "Ober Operation." The meeting held September 2 was devoted to the consideration of a report by the Special Medical Economics Committee.

\* \* \*

WASHINGTON-HOLMES COUNTY MEDICAL  
SOCIETY

From Dr. R. H. Segrest, secretary of the Washington-Holmes County Medical Society, comes the following encouraging report: "We are doing good work, I think, with our small society. We have only eight members but from five to eight are generally present at each month's meeting, which is held every fourth Thursday. We will be glad to have visitors at any time."

\* \* \*

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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**A Survey of Childhood Pneumonias**—ROSE, JOSEPH, Washington, D. C. (now of Jacksonville); SCHAPIRO, MARK M., and McLARNEY, EDWARD P., Washington, D. C. *Med. Ann. Dist. Col.*, Vol. 7, (Feb.), 1938.

Rose, Schapiro and McLarney present a statistical study of pneumonias consecutively admitted to The Children's Hospital of Washington, D. C. between January 4, 1936, and December 26, 1936. The cases are divided into lobar and lobular (or disseminated) pneumonias.

Four hundred twenty-three children were studied. "243 were of the lobar and 180 of the lobular type. Up to 2 years of age lobular pneumonia occurred in 62.7% with a mortality of 46.9%. For the same age group 39.5% were lobar with a mortality of 12.5%. In the group 2 years and over lobar was present in 60.4% with a mortality of 8.8% while the lobular were 37.2% and mortality 19.4%."

Complications were more frequent in the early age group and particularly in the disseminated form. In the older age groups complications were more frequent with the lobar type. Empyema was the primary complication in both types and at all ages.

A most interesting feature of the study is the fact that the authors were unable to find a single case of otitis media in the entire 423 cases.

**The Effect of Immune Blood Upon the Opsonocytaphagic Power of the Blood in Pertussis**—BRADFORD, WILLIAM L., New York; MIKELL, RORERT, New York (now of Lakeland, Fla.); and SLAVIN, BETTY, New York. *J. Clin. Investigation* 16:829-832 (Sept.) 1937.

Bradford, Mikell and Slavin are of the belief that young infants do not respond well to antigenic stimulation, and that the time interval necessary for active immunization against pertussis renders vaccines unsuited for protection against imminent contact.

The effect of immune blood in the produc-



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tion of protection against this disease is studied from the standpoint of its effect upon the opsonocytaphagic powers of the blood.

The results obtained from their experimentation were as follows:

1. The blood of 10 of a group of 11 children showed marked increase in phagocytic power against *H. pertussis* when a small amount of adult immune serum was added.

2. With 9 infants phagocytosis was definitely increased by intravenous blood transfusion.

3. There was definite but less marked increase in phagocytosis in 5 infants receiving 20 cc. of adult immune blood and 13 receiving 10 cc. of hyperimmune serum intramuscularly.

4. There was a definite increase in phagocytosis in 3 infants receiving 10 cc. of placental extract intramuscularly.

The authors attempt no clinical conclusions from their findings.

**Bone Regeneration Following Maggot Therapy in Compound Fractures**—SIMON, H. THEODORE, New Orleans; HAMILTON, A. SCOTT, New Orleans; and FARRINGTON, CHARLES L., New Orleans, (now of Tampa, Florida), *J. Bone & Joint Surg.*, **19**:985-992 (Oct.) 1937.

Simon, Hamilton and Farrington advocate the use of massive implantations of sterile maggots into all severe compound comminuted fractures.

Their technique, at some variance from that in general use, is briefly as follows:

An incision is made comparable to the area of bony comminution, unless primary exposure is sufficiently large. A thin layer of sterile gauze is inserted deep into the wound to eliminate all dead space. Under aseptic precautions, approximately 5,000 twenty-four-hour old maggots are laid on the gauze in the depths of the wound. Four to six inches of sterile gauze is placed over the wound. This gauze dressing is changed every 6 to 8 hours. Within 24 to 48 hours the maggots mature and are removed as they no longer feed but merely crawl from place to place.

Several changes in the wound are noted as a result of this method of treatment. In contaminated but not infected lacerations very little pus appears and healthy pink gran-



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ulations are early. Grossly infected wounds are rapidly cleaned of their dirty gray granulations, discharge of pus is diminished and the odor is improved. Sequestrectomy is seldom necessary as the maggots loosen non-viable fragments, making easy their removal during routine dressing.

The authors describe four illustrative cases.

## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

ANUS, RECTUM, SIGMOID COLON. By Harry Ellicott Bacon, B.S., M.D., F.A.C.S., F.A.P.S., Asst. Prof. of Proctology at Temple University School of Medicine and at Graduate School of Medicine, University of Pennsylvania; co-founder and past president, Proctologic Society Graduate Hospital, U. of P.

J. P. Lockhart-Mummery, R.F.C.S. (London), in his foreword to this book, says: "This book of Doctor Bacon's \* \* \* should prove of value to all proctologists as a work of reference. It covers a wide field and the author has studied the literature on the subject in almost every country where anything of importance has been published within recent years. There is a very full and comprehensive bibliography attached to each chapter, which alone should give the book a well-merited place upon any proctologist's library shelf."

Dr. W. Wayne Babcock of Philadelphia wrote the introduction to the book and includes in his comment: "For years Doctor Bacon has been one of the most diligent of that group of intensive workers led by Collier Ford Martin, and with a judgment acquired by much clinical observation he has written a most practical book. It contains a wealth of information from which the specialist may refresh his memory, while the practitioner will find the way to clarify his difficulties; or if the case seems beyond his experience, he will be guided to arrange for the most approved form of treatment. Doctor Bacon's book is the most complete and detailed work on proctology I have yet seen."

Cloth, pp. 855, with 487 illustrations. Philadelphia: J. B. Lippincott Co., 1938.

OUTLINE OF ROENTGEN DIAGNOSIS—AN ORIENTATION IN THE BASIC PRINCIPLES OF DIAGNOSIS BY THE ROENTGEN METHOD. By LEO G. RIGLER, B.S., M.B., M.D., Professor of Radiology, University of Minnesota. This volume is divided into eleven sections, as follows: General Principles of Roentgen Diagnosis; Bones and Joints (normal characteristics, traumatic conditions, infectious diseases of bones, bone tumors, diseases of bones of children, miscellaneous bone diseases, diseases of joints); Diseases of Spine and Spinal Cord; Skull and its Contents; Thorax (respiratory tract, pleura, heart and great vessels, mediastinum, diaphragm); Digestive Tract (esophagus, stomach and duodenum, small intestine and appendix, colon); Gallbladder; Abdomen; Urinary Tract; Female Generative Organs; Miscellaneous.

This book has been made up in two formats. One, in which the 254 illustrations and x-rays are grouped in atlas fashion with numerous references and cross references in the text to the atlas section, is priced at \$6.50, pp. 335. The other is a student edition, from which the atlas section has been omitted and is priced at \$3.00, pp. 212. Philadelphia; J. B. Lippincott Company, 1938.



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## ADVERTISERS' NOTES

## RE-OPENING OF CLEAR LAKE LODGE

Clear Lake Lodge Sanitarium, Orlando, formerly operated by the late Dr. C. D. Christ and suspended shortly after his demise, was reopened September 5, with Mrs. Grace H. Lochman, R. N., as manager and superintendent and W. Henry Spiers, M. D., neuropsychiatrist, medical director.

This institution is equipped to give insulin, fever, and malarial treatment under proper supervision; also hydrotherapy, physiotherapy and occupational therapy when deemed advisable. Expert dietetic procedure will be observed.

Only those patients referred by regular medical doctors will be accepted. This institution does not cater to, but will take selected voluntary cases of alcoholism and drug addiction, when the method of treatment outlined by the institution is accepted by the patient.

Clear Lake Lodge Sanitarium is located on the eastern shore of beautiful Clear Lake, three miles from the center of Orlando. No more pleasant site could have been selected for such an institution, with its placid serenity away from the noisy traffic. Located in the center of the state, it is easy to reach by automobile since Orlando is the hub of Florida's good roads; railroad facilities, too, are excellent.

Mrs. Lochman is a registered nurse who served in the Medical Corps of the United States Army during the War as chief nurse of the Walter Reed Hospital in Washington, and has had several years' experience with nervous and mental patients. She has under her a corps of specially trained nurses and attendants who will contribute much to the comfort of the patients.

Dr. W. Henry Spiers is well known in Florida medical circles, having been resident physician at the Florida State Hospital in Chattahoochee approximately six years. During the last two years of his association with this institution he was clinical director, and has had over twenty years' experience with mental disorders.

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For several years the liver extracts prepared by Eli Lilly and Company have been standardized on patients with Addisonian pernicious anemia in relapse and the accuracy of the method has now been attested by the official acceptance of Liver Extract, Lilly, Solution Liver Extract, Lilly, and Solution Liver Extract Concentrated, Lilly.

## SQUIBB INSTITUTE FOR MEDICAL RESEARCH

Organization of the Squibb Institute for Medical Research, in which a staff of scientists assembled from leading institutions of the United States and foreign countries will attack problems involved in the cure of disease and relief of pain, is announced by E. R. Squibb and Sons. The Institute will be housed in a new laboratory building just constructed at a cost of \$750,000 in New Brunswick, N. J., and described as "the finest of its type in the world."

Dedicated to pure science, the Institute, which will be in complete operation this Fall, is the first of its kind to be founded in the pharmaceutical industry. The aim, it was explained, is to create in the medical and biological fields an industry-supported research enterprise comparable to the Bell Telephone and General Electric laboratories in the sphere of physics.

Research activity, already under way, has been organized in four main divisions—experimental medicine, pharmacology, bacteriology and virus diseases, and organic chemistry. In addition, the Institute will operate a biochemical laboratory and a medicinal chemistry laboratory. The scientists will continue studies begun in the laboratories with which they were previously associated, and new lines of investigation will be opened up.



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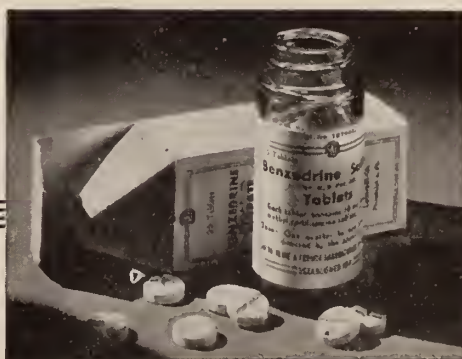
# BENZEDRINE SULFATE TABLETS

have been accepted

by

The Council on Pharmacy and Chemistry  
of the American Medical Association

*The announcement of acceptance appeared  
in the July 2nd issue of the J. A. M. A.*



Each 'Benzedrine Sulfate Tablet' contains amphetamine sulfate, 10 mg. (approximately 1/6 gr.)

The Council on Pharmacy and Chemistry of the A. M. A. has adopted amphetamine as the descriptive name for  $\alpha$ -methylphenethylamine, the substance formerly known as benzyl methyl carbinamine. 'Benzedrine' is S. K. F.'s trademark for their brand of amphetamine.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.  
*Established 1841*

"IS THIS PRODUCT COUNCIL-ACCEPTED?"

This is the first question many physicians ask the detail man, when a new product is presented.

If the detail man answers, "No," the doctor saves time by saying, "Come around again when the Council accepts your product."

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No one physician, even if he were qualified, could afford to devote so much time and study to every new product. His Council renders this service for him, freely. Nowhere else in the world is there a group that performs the function so ably served by the Council on Pharmacy and Chemistry and the Council on Foods.

Mead Johnson & Company cooperates with both Councils, not because we have to but because we want to. Our detail men can always answer you, "Yes, this Mead Product is Council-Accepted."

#### CATARACT TEST LENS SET

A new and improved Tillyer DeLuxe Senior Cataract Test Lens Set which gives a wider sphero cylinder range, a greater selectivity, and which simplifies the technique has just been announced by American Optical Company.

The range of cylinders in the sphero cylinder group has been extended to give a total sphero cylinder range in  $\frac{1}{4}$  Diopters of .25 to 6.00 D. cyl combined with 8.00 to 18.00 D. sphero.

All lenses are mounted in special rings and finished in Rhodium. Spherical and cylindrical powers are clearly engraved on the ring handles. The set comes in all wood tray and leather covered office style case. There are 89 lenses in the set.

Your American Optical Company representative will be glad to give you further details of this new Tillyer Cataract Test Lens Set.



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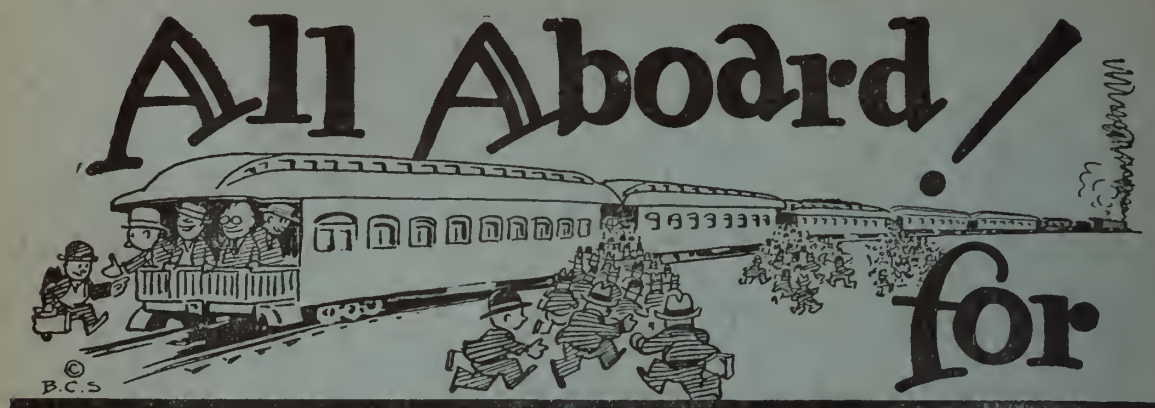
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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Districts	COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Panama City July 14, 1938	Bay	W. J. Blackshear, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'40 Carol C. Webb, M. D., Pensacola	11	100%
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		42	38
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		Santa Rosa	8	100%
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	16	13
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	Calhoun-Franklin-Gulf	38	35
North Central District (B) Gainesville, October 27, 1938	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanch Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	18	15
	Madison	E. Long, M. D., Madison				4	3
	Taylor	Ralph J. Greene, M.D., Perry	W. J. Baker, M. D., Foley	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton-Lafayette-Suwannee	8	6
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M. D., McIntosh	27	22
	Marion	Carney W. Mimms, M. D., Commercial Bank Bldg., Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	21
	Pasco-Hernando-Citrus	Samuel C. Harvard, M. D., Brooksville	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		14	12
N. E. District (C) Ponte Vedra Sept. 15, 1938	Sumter	Clyde L. Carter, M.D., Wildwood		2nd Tuesday	Bradford-Gilchrist-Levy-Union	5	100%
	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	161	145
	St. Johns	John J. Spencer, M.D., 32 Saragossa St., St. Augustine	Vernon A. Lockwood, M.D., East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganious, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M. D., Daytona Beach	10	100%
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258 1/2 S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	39	34
	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St., Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsbrook, M. D., Plant City	108	95
Southwest District (D) Bradenton, September 29, 1938	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		13	100%
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		90	100%
	Sarasota	O. H. Cribbina, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		15	12
	DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring	Howard V. Weems, M.D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Wataon, M. D., Lakeland	20	18
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	11
	Polk	W. W. Shafer, M. D., Haines City	J. B. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Charlotte-Collier-Glades-Hendry	64	55
South Central District (E) Eustis, Nov. 10, 1938	Brevard	G. E. Christie, M.D., Titusville	I. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M. D., Cocoa	12	100%
	Lake	Harry T. Fenn, M. D., Mount Dora	W. L. Aabton, M. D., Umatilla	1st Thursday 12:30 P. M.		16	100%
	Orange	H. A. Day, M.D., 209 Exchange Bldg., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		72	100%
	Seminole	J. N. Tolar, M. D., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	Osceola	13	100%
	St. Lucie-Okeechobee-Indian River-Martin	R. C. Boothe, M.D., Ft. Pierce	Adrian M. Sample, M.D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	16	100%
	Broward	A. B. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M. D., West Palm Beach	31	100%
S. E. District (F) Ft. Lauderdale Oct. 13, 1938	Palm Beach	V. M. Johnson, M.D., Good Samaritan Hospital, W. Palm Beach	J. R. Sory, M.D., 516 Harvey Bldg., West Palm Beach	4th Monday 8:00 P. M.		56	55
	Dade	Arthur H. Welland, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzer, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	280	258
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	100%

# FLORIDA SPECIAL TO SOUTHERN MEDICAL ASSOCIATION



## OKLAHOMA CITY, OKLAHOMA

For the convenience of members attending the Southern Medical Association meeting, Oklahoma City, November 15-18, arrangements have been made with the ATLANTIC COAST LINE RAILROAD for operation of special air conditioned sleeper from Jacksonville to Oklahoma City, leaving Jacksonville at 9:00 p. m., November 13. It will arrive in Memphis 7:00 p. m., November 14, where your Pullman will be attached to a special train arranged by Mr. C. P. Lorz, Secretary-Manager, Southern Medical Association. This train leaves Memphis over Rock Island, 7:30 p. m., November 14, and arrives at Oklahoma City, 7:30 a. m. the following morning. It is intended to concentrate the entire southeastern group at Memphis, operating a special train to Oklahoma City and return.

Following are rates and schedules from a few points in Florida. Rates from other points in Florida can be obtained from your local ticket agent.

### ROUND-TRIP FARES

STARTING POINT	FARE
Tampa .....	\$59.55
St. Petersburg .....	60.60
Orlando .....	59.05
Gainesville .....	54.15
Miami .....	69.30
West Palm Beach .....	66.30
Daytona Beach .....	58.25
Jacksonville .....	53.30

### SCHEDULES

STARTING POINT	ROUTE	TIME	DATE
Lv. Tampa .....	A. C. L.	11:35 a. m.	Nov. 13
Lv. St. Petersburg .....	A. C. L.	10:30 a. m.	" 13
Lv. Orlando .....	A. C. L.	2:05 p. m.	" 13
Lv. Gainesville .....	A. C. L.	4:18 p. m.	" 13
Lv. Miami .....	F. E. C.	11:00 a. m.	" 13
Lv. West Palm Beach .....	F. E. C.	12:40 p. m.	" 13
Lv. Daytona Beach .....	F. E. C.	4:52 p. m.	" 13
Lv. Jacksonville .....	A. C. L.	9:00 p. m.	" 13
Ar. Birmingham .....	C. of Ga.	11:30 a. m.	" 14
Ar. Memphis .....	Frisco	7:00 p. m.	" 14
Lv. Memphis .....	R. I.	7:30 p. m.	" 14
Ar. Oklahoma City .....	R. I.	7:30 a. m.	" 15

Due to commitments made by the Atlantic Coast Line to officers of the Southern Medical Association, fares quoted are those in effect prior to the increase in fares on September 1, involving considerable saving.

Pullman reservations can be made through any Atlantic Coast Line or Florida East Coast ticket agent or passenger representative.

# The JOURNAL of the Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XXV  
No. 4

Jacksonville, Florida, October, 1938

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American Medical Association, St. Louis, May 15-19, 1939  
Florida Medical Association, Daytona Beach, 1939  
Southern Medical Association, Oklahoma City, November 15-18, 1938

Entered as second-class matter under Act of Congress of March 3, 1879,  
at the Postoffice at Jacksonville, Florida, October 23, 1924



# RECENT ADVANCES IN THE SCIENCE OF NUTRITION

## II. Newer Knowledge of the P-P Factor and the Control of Endemic Pellagra

● The years since 1932, when the P-P factor was known variously as vitamin B<sub>2</sub> or G, have been especially marked by contributions to our knowledge of the anti-pellagic vitamin. Considerable progress has also been made in the treatment of human pellagra as well as in the control of the disease. It might be of interest to review briefly a few of the outstanding developments in this field.

The P-P factor is now accepted as being closely related chemically to nicotinic acid if, indeed, it is not identical with that compound (1). Nicotinic acid has been used successfully in the treatment of human pellagra (2) and there is evidence to support the belief that the P-P factor is intimately associated with essential enzyme reactions in the body (3). A laboratory test has been devised for the early clinical detection of pellagra (4) and there is today better agreement as to the basic dietary requirements for the management of florid pellagra (1).

While the situation as regards endemic pellagra has, in general, shown improvement during recent years, an occasional report indicates that endemic pellagra still constitutes a major medical problem in some localities (5). Authorities agree that the old adage relating to an ounce of prevention being the equal of a pound of cure applies particularly well in the case of pellagra. Consequently, in specific regions of this country certain control measures have been advocated in an endeavor to bring this deficiency disease under permanent control. The most promising of these measures are

the issuance of yeast rations and popular education to the desirability of home production of foods rich in the P-P factor, especially during late winter and early spring. The problem of permanent control of pellagra has been clearly and briefly defined as follows:

"The prevention of endemic pellagra is simple in theory but difficult in practice. If every normal person received enough of the foods containing the pellagra-preventive vitamin there would be no endemic pellagra.—Permanent control can be obtained only by bringing about permanent changes in dietary habits" (1).

The correction of those long-standing dietary malpractices which are responsible for pellagra is certain to be brought about only slowly. The concerted and sustained efforts of all agencies concerned with public health will be required, not only to insure observance of the control measures described above, but also to educate the potential pellagrin to the necessity of a varied diet of protective foods.

Commercially, canned foods may play an important part in the current program designed to bring pellagra under control. Several hundred varieties of canned foods are readily available on every American market at all seasons of the year. Judicious inclusion in the diet of those foods known to be important carriers of the anti-pellagic factor (1) should materially assist in effecting permanent control of endemic pellagra in America.

## AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

(1). 1938. J.A.M.A. 110, 1665.

(2). 1938. J.A.M.A. 111, 584.

1938. Ibid. 111, 613.

1938. Ibid. 110, 289.

(3). 1938. J.A.M.A. 111, 28.

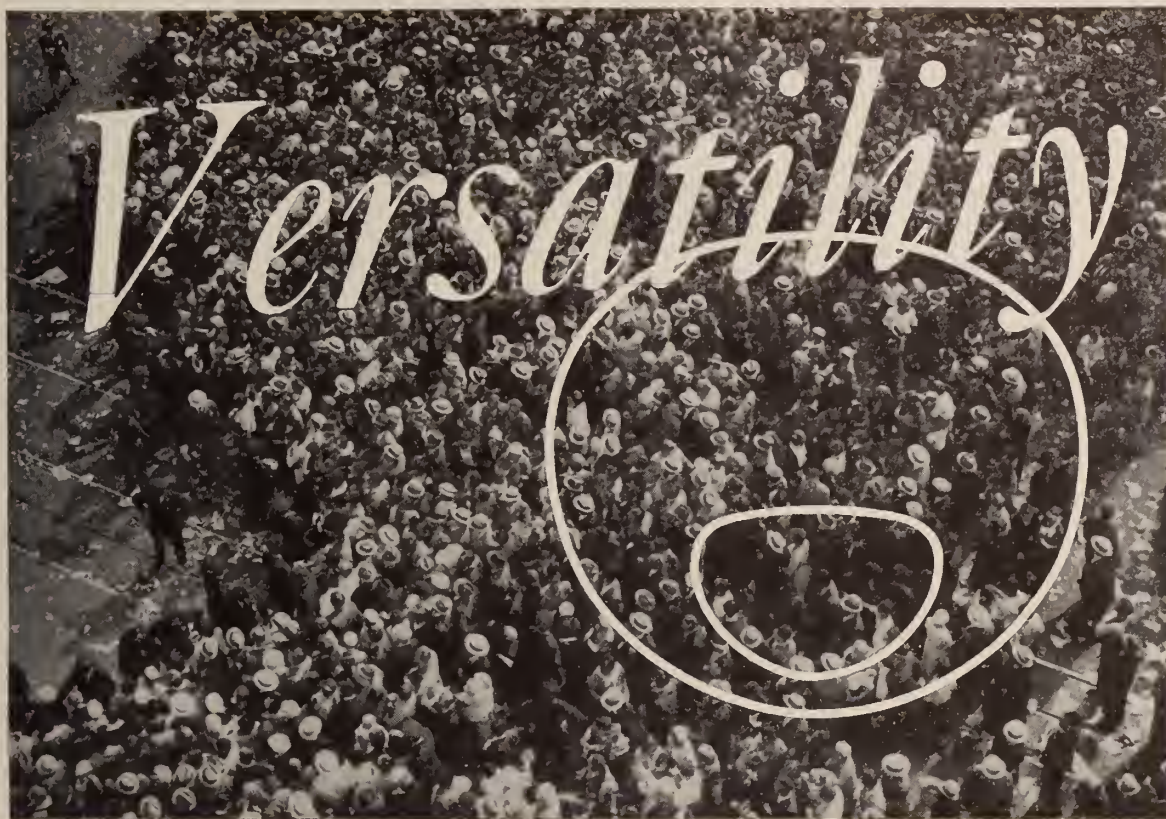
(4). 1938. J. Med. Assn. State of Alabama. 8, 52.

(5). 1938. J. Med. Assn. State of Alabama. 7, 475.

*This is the forty-first in a series of monthly articles, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research. We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.*



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.



## ***Panoptik Bifocals Fill a Broad Range of Requirements***

No one knows better than you—that patients have an amazingly wide variety of bifocal requirements. Consequently, it pays to standardize on AO Panoptik Bifocals—because of their outstanding versatility.

*Mrs. X*, housewife, aged 43; wants to avoid the appearance of wearing bifocals.

*Mr. D*, physics professor, aged 50, is disturbed by chromatic aberration in scientific observations.

*Mr. C*, proof reader, 48, has been plagued all his life with headaches because of vertical imbalance introduced by glasses.

*Miss H*, teacher, 60, fears bifocal "jump."

In every case Panoptik Bifocals fill the requirements. They banish "jump"! They permit control of the position, size and shape of segments. They provide marginal correction vision and eliminate chromatic aberration. For patient satisfaction, AO Panoptiks are recommended by thousands of refractionists the country over.

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In the past a frequent complaint from mothers was the expense incurred when the large bottle of antiricketic was accidentally upset.



## OLEUM PERCOMORPHUM

Even if the bottle of Oleum Percomorphum is accidentally tipped over, there is no loss of precious oil nor damage to clothing and furnishings. The unique Mead's Vacap-Dropper\* is a tight seal which remains attached to the bottle, even while the antiricketic is being measured out. Mead's Vacap-Dropper offers these extra advantages also, at no increase in price:

### Unbreakable

Mead's Vacap-Dropper will not break even when bottle is tipped over or dropped. No glass dropper to become rough or serrated.

### No "messiness"

Mead's Vacap-Dropper protects against dust and rancidity. (Rancidity reduces vitamin potency.) Surface of oil need never be exposed to light and dust. This dropper cannot roll about and collect bacteria.

### Accurate

This unique device, after the patient becomes accustomed to using it, delivers drops of uniform size.

### No deterioration

Made of bakelite, Mead's Vacap-Dropper is impervious to oil. No chance of oil rising into rubber bulb, as with ordinary droppers, and deteriorating both oil and rubber. No glass or bulb to become separated while in use.

### How to Use MEAD'S Vacap-Dropper

Remove both top and side caps. Wipe dropper tip. Regulate rate of flow by using finger to control entrance of air through top opening (see below). Oleum Percomorphum is best measured into the child's tomato juice. This is just as convenient and much safer than dropping the oil directly into the baby's mouth, a practice which may provoke a coughing spasm.

\*Supplied only on the 50 cc. size; 10 cc. size is still supplied with the ordinary type of dropper.

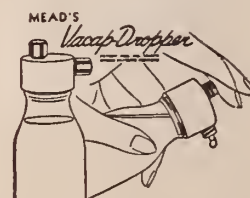
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More Economical Now Than Ever

MEAD JOHNSON & CO., Evansville, Indiana, U. S. A.

U. S. Patent Nos. 2105023 and 101575

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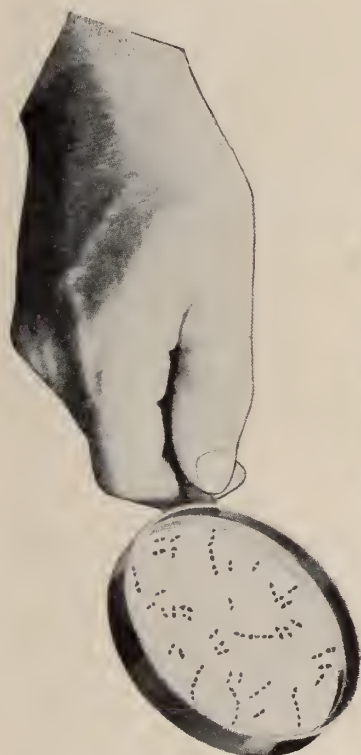
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The Research and Biological Laboratories of The National Drug Company are dedicated to the development of biologicals, biochemicals and pharmaceuticals that will better serve in prophylaxis or treatment of disease, and so better assist physicians and surgeons in protecting and safeguarding life and health.

## SCARLET FEVER ANTITOXIN (NATIONAL)

A Real Achievement in Concentration and Refinement of the globulin fraction reducing the volume and because of low content of non-essential serum proteins, decrease serum reactions.

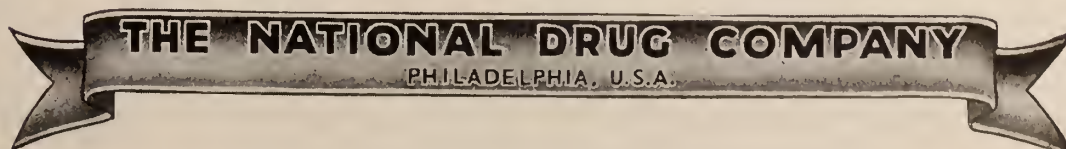
Smaller volume is more quickly absorbed.

Gives quicker therapeutic response.

The advantages of a highly refined and concentrated Scarlet Fever Antitoxin should materially increase its use for prophylaxis (passive immunity), and for the treatment of scarlet fever patients.

*Write for literature on Scarlet Fever Antitoxin (National)*

F. M. A. 10-38



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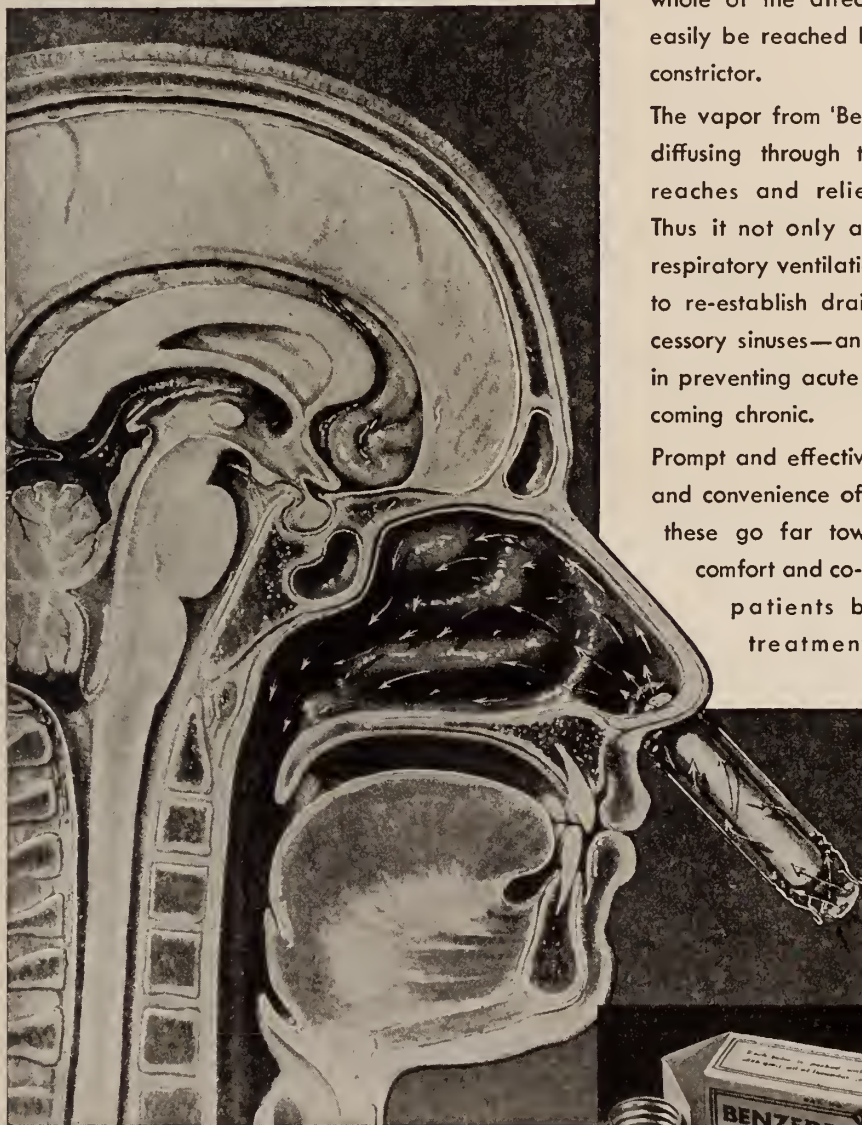
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# IN SINUSITIS



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The vapor from 'Benzedrine Inhaler,' diffusing through the nasal cavity, reaches and relieves congestion. Thus it not only affords improved respiratory ventilation, but also helps to re-establish drainage of the accessory sinuses—an important factor in preventing acute attacks from becoming chronic.

Prompt and effective relief . . . ease and convenience of application . . . these go far toward insuring the comfort and co-operation of your patients between office treatments.



## BENZEDRINE INHALER

A Volatile  
Vasoconstrictor



Each tube is packed with amphetamine, S.K.F., 0.325 Gm.; oil of lavender, 0.097 Gm.; menthal, 0.032 Gm. 'Benzedrine' is S.K.F.'s trademark, Reg. U. S. Pat. Off., for their nasal Inhaler and for their brand of amphetamine. Amphetamine was formerly known as benzyl methyl carbinamine, Pat. Nas. 1879003, 1921424 and 2015408.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA • EST. 1841

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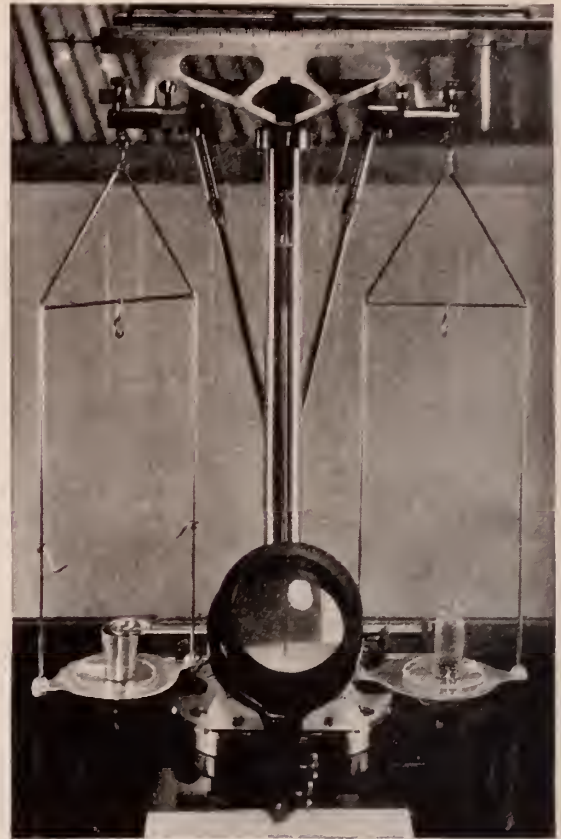


# DELICATELY BALANCED

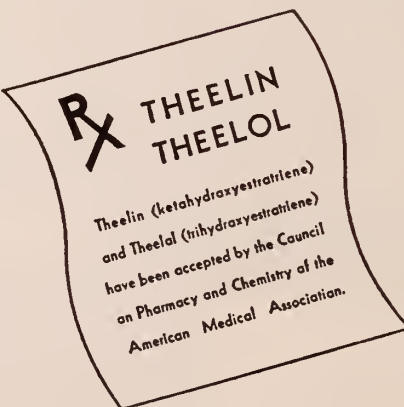
Throughout woman's reproductive years a delicate balance is normally maintained between ovarian and other hormones.

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## QUININE AMBLYOPIA IN CHILDREN\*

LUTHER W. HOLLOWAY, M.D.,  
Jacksonville.

Florida in common with other Southern States embraces areas in which malarial fever is endemic. These areas are well defined geologically as brought out by Boyd<sup>1</sup> in 1933. Limestone substrata are found uniformly.

In the South, many persons take quinine in its various forms without medical direction for many febrile disturbances not necessarily of malarial origin. There are a few members of the medical profession who still prescribe quinine for a medley of fevers which do not result from malarial infection. As a consequence of this practice, many eye, ear, and other special nerve disabilities result which may be of a permanent nature.

In 1841, three years less than a century ago, Giacomini<sup>2</sup> reported the first case of quinine amblyopia. The patient became unconscious, blind and deaf in sequence from taking quinine. "Blindness and deafness lasted a long time." Von Graefe<sup>3</sup> in 1857 reported two cases of quinine amaurosis. Knapp<sup>4</sup> in 1881 reported the first three cases of quinine amaurosis in children, ages seven, seven, and eight years respectively. These children were unable to see anything for varying periods of time. Gradually, however, according to the record, they recovered their central vision but not their peripheral vision.

In 1884 Fox<sup>5</sup> reported a case of a boy thirteen years of age, who lost his vision twice within three months as a result of the administration of quinine. This child was reported to have recovered as a result of the use of hydrobromic acid. Time of recovery was not stated.

Bruns<sup>6</sup> of New Orleans, Louisiana, in 1897 reported a case in a three year old female who became blind after the use of thirty grains of quinine for remittent fever. "The pupils

were dilated to the maximum; and responded only slightly to bright light; ophthalmoscope showed the optic discs very white with the vessels, and especially the arteries, small and thin. Under treatment with strychnine, there was gradual improvement in vision; in less than a month the vision seemed normal. Subsequent examinations over a period of ten years showed the pupils dilated, optic discs bluish white and the arteries small." The same author reported another case twenty-three years after onset: "The pupils not noticeably abnormal but during ophthalmoscopic examination they remained more widely opened than usual. Optic atrophy of the last stages was present with the nerves a pale, bluish white and the vessels very tenuous. With proper glasses the patient read fine print at usual distance." No measurement of visual fields was made in either case.

In the same year Ayres<sup>7</sup> reported the case of a girl infected with chickenpox, who was given quinine to control an unusually high fever. Large doses, twenty-four, fifty-six and twenty-six grains, were given. She became unconscious for two or three days, and was then totally blind, vision returning gradually. Examination two months later showed vision six-tenths (6-10) each eye. Improved color sense had returned, optic discs remained pale.

Moulton<sup>8</sup> reported two cases in 1901. One was of a negro child eight years of age whose visual fields were contracted, the retinal vessels small, the optic nerve heads pale. At the age of four years the child had been given heavy doses of quinine and had been blind a few days, but was now in good health. In the second case, a young woman nineteen years old was examined for an error of refraction. The central vision was good, the visual fields were contracted, the discs were white with all details distinct and the retinal vessels contracted. At the age of four years the patient had taken one ounce (480 grains) of quinine over the period of one week during an attack of measles. She was practically blind for many weeks, but had recovered useful vision at the end of five months.

\*Read before the Sixty-fifth Annual Meeting of the Florida Medical Association, held at Miami, May 9, 10 and 11, 1938.

In 1905 Gioseffi<sup>9</sup> noted that "quinine is better tolerated by children than by adults. \* \* \* By experiments on animals it has been shown that young animals can tolerate larger doses than older ones." No injury to the fetus was caused by quinine given for malaria in the pregnant mother. Goth<sup>10</sup> reported that no bad results occurred from quinine given to forty-six cases of pregnancy with concomitant malarial infection. He reported several cases of quinine poisoning in children who had been given doses ranging from two to five grams of the drug. The only unusual symptoms noted were dilated pupils and sluggish reaction to light. No report of the examination of the fundi in any of the cases was made; no loss of vision mentioned.

In 1916 Shahan<sup>11</sup> noted that quinine amblyopia was becoming rare due to greater care in the administration of the drug. "It is most likely to be found in cases where more enthusiasm than wisdom is used in its administration." In 1920 Wunderlich<sup>12</sup> concluded that quinine amblyopia and the consequent vascular constriction and ischemia are not the essential and primary factors in causing loss of vision in quinine poisoning, but that there is a primary injury to the nerve elements. The changes in the blood vessels are concomitant or secondary.

Marshall Taylor<sup>13</sup> has very pertinently called to the attention of the profession that quinine administration to pregnant women may permanently affect the auditory apparatus of the fetus, thus giving rise to a state of congenital deafness. Shaler Richardson<sup>14</sup> has reported two cases of infants, five and one-half and six and one-half months respectively, who apparently were made blind by the prenatal administration of quinine. Ophthalmoscopic examination revealed the picture of pale nerve heads with the blood vessels much reduced in calibre.

De Schweinitz<sup>15</sup> concluded from his experiments on dogs that the toxic effect of quinine primarily was upon the vasomotor centers and that the drug exerted a selective effect on the optic nerve. Holden<sup>16</sup> said there was no way

to determine exactly how far the degeneration of the ganglion cells and their axis cylinders may be due to the direct toxic action of the cinchonized blood. Druault<sup>17</sup> concluded that blindness from quinine is due primarily to the toxic effect of the drug on the ganglion cells of the retina and the optic nerve, and the primary lesion is that of the ganglion cells, the vasoconstriction probably playing some accessory part in the production of the degenerative changes in the nerve cells.

#### CASE REPORTS

Case 1.—In 1923, J. V., female, fourteen months old, was brought to me with the complaint of chills and fever for seven weeks with blindness of two weeks' duration. She had received quinine sulfate, eight grains daily by mouth, for two weeks when the toxic effect of the drug was manifested by extreme nervousness and vomiting. For two additional weeks she received quinine intramuscularly, at the end of which time she became unable to see her toys. The physical examination revealed the following positive findings: a markedly dehydrated female with fever 105 degrees by rectal record; a total white count of 19,250 cells with a polymorphonuclear leukocyte cell count of 78; the urine contained albumin, two plus, and acetone three plus. Microscopic study of urine showed a solid field of pus cells. Dr. Shaler Richardson examined her eyes and found "no light perception, pupils moderately dilated with sluggish reaction to light, the nerve heads very white with clear cut markings; the blood vessels greatly attenuated and the retinae pale." The fundi presented a picture of advanced primary optic atrophy.

A gloomy prognosis was given as to recovery of vision. The guardians sought other advice and the child was observed for several years by Doctors Heggie and Knauer. The vision returned in four months. At this time, fifteen years after her initial injury, she has only central vision. The slide demonstrates the permanently marked constriction of her visual fields which is a result of the administration of quinine to a small child whose real infection was a pyclopnephritis (*Fig. 1*).

Case 2.—A. B. was seen eight years ago when the patient was thirteen years of age. According to the history this child had suffered from chills, fever and pains in his legs at intervals over a period of several months. Quinine was administered with each episode of fever, chills and pain. He finally became blind after receiving quinine dihydrochloride daily by needle in the amount of seven and one-half grains for a period of four weeks. Blindness persisted for eight or nine weeks after which time he gradually began to see again. Eight years later he now has only central vision. The nerve heads are very pale and the blood vessels are extremely attenuated. A slide shows the degree of constriction of the visual fields (*Fig. 2*).

The infection from which this patient suffered was acute osteomyelitis. The infection became chronic and as a result one leg was amputated at the hip and there is a flaccid paralysis of the remaining leg.

At the present time he is learning the watchmaker's trade. He will be able to successfully use his remaining central vision in this work.



*The above illustrations reproduced through courtesy of Dr. Shaler Richardson, Jacksonville, with permission from Southern Medical Journal. ("The Toxic Effect of Quinine on the Eye," Southern M. J. 29: 1156-1164).*



Case 3.—J. B. H., Jr., two year old male, received thirty-two grains of euquinine for a period of three to four days for a high fever. On the third day he began to vomit and became very restless. His pupils became widely dilated and vision suddenly disappeared. This child was seen by me two hours after loss of vision. Observation of this case began earlier than in any of the other cases on record.

Dr. Shaler Richardson immediately examined this child for me and reported: "The pupils are dilated ad maximum and do not react to stimuli; the ocular media are clear; the nerve heads are slightly paler than normal, also the retinae; the blood vessels are somewhat constricted."

The examination of this child revealed the following positive findings: temperature 104 degrees rectal; the pyrexia lasted four more days ranging from 102 to 105 degrees. There was present an acute follicular tonsillitis. The total white count was 21,450 and the polymorphonuclear leukocytes numbered 80. At times the pupils became less dilated but when acetylsalicylic acid was given for the high fever they again dilated fully. This demonstrated that there was a sensitivity for this drug also. Spiritus etheri nistrosi was given for its vasodilator and diuretic effects. With local treatment to the throat the fever subsided and remained normal. This child remained blind for two months, at which time he gradually began to recover his vision. It was a pitiful exhibition to see him stumble over and run into articles of furniture which were in his line of walk.

Three years since his illness began, his vision is still limited to objects which are in line with his central vision.

Ophthalmoscopic examination at the present time shows that his ocular apparatus remains in status quo as of the time of his initial injury. The film demonstrates his inability to perform acts which a child with normal vision readily does. Due to the age of the patient, sufficient cooperation could not be enlisted to reveal visual fields accurately. Further observations will be made.

Case 4.—In a personal communication from Dr. H. Mason Smith, Tampa, Florida, another case is reported briefly. He observed a case of quinine amblyopia in a child eighteen months of age. This child had an infection of some nature with high fever. This child received coco-quinine, one teaspoonful four times daily, with an additional five grains of quinine to each teaspoonful, making a total of seven grains per dose four times daily for two weeks. This child's vision was lost completely at the end of two weeks. No malaria parasites were demonstrated, but pyuria was present. The patient has recovered central vision in about four weeks. Dr. Blackburn Lowry of Tampa, Florida, made the ophthalmological examination and reported findings typical of quinine amblyopia.

From observation of quinine amblyopia in young children over a period of fifteen years, it is my belief that they are more susceptible than are older and more mature persons, and that their degree of recovery is, also, markedly less. Of course, idiosyncrasy to quinine is the primary predisposing factor to amblyopia, but too large dosage aggravates the condition. In cases where fever is the main symptom, it is our duty to differentiate by all possible aids and ascer-

tain, if possible, the infection which is present before administering any drug which may cause permanent damage to the susceptible recipient. It is incumbent upon us as physicians to teach the fathers and mothers of our patients the fact that self-medication is a dangerous procedure.

#### SUMMARY

1. Amaurosis and amblyopia resulting from the use of cinchona derivatives have been described in the literature during the last century. Only a small percentage of these cases have been reported in children.

2. The administration of quinine was not indicated in any of the four cases reported in this paper, it having been proved subsequently that in Case I the condition was pyelonephritis; in Case II, chronic osteomyelitis; in Case III, follicular tonsillitis; and in Case IV, pyelitis.

3. It would seem that quinine is often indiscriminately used before an actual diagnosis is made.

4. Certainly, the indiscriminate use of quinine in children may result more disastrously than in adults for the reason that young children do not or cannot make known their subjective symptoms.

5. It is not the purpose of this paper to decry the use of so valuable a remedy as quinine, but merely to present the dangers that may occur from such a drug when it is improperly used or where idiosyncrasy exists.

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#### DISCUSSION

*Dr. Nelson M. Black, Miami:*

I would like to ask the essayist if he has seen any reports of quinine amblyopia or amaurosis in which quinine was given strictly for a malarial condition.

Quinine is a very, very important drug as we all know in the treatment of malarial conditions, and personally as far as I can remember I cannot recollect of seeing a case of quinine amblyopia the result of giving quinine for malarial conditions. So we do not want to deprive the general practitioner of the use of quinine in malarial conditions.

*Dr. Shaler Richardson, Jacksonville:*

The subject of quinine amblyopia has been of particular interest to me for some years. I saw my first case as long ago as 1923 and since that time have seen some thirteen cases.

In 1936 I read a paper entitled "The Toxic Effects of Quinine on the Eye" before the Southern Medical Association. At that time I stated definitely that it was not the purpose of the paper to condemn the use of so valuable a drug as quinine, but for the implied purpose

of bringing to the attention of those prescribing quinine, the danger of visual loss which sometimes results.

General practitioners have said to me: "What are we going to do, discontinue the use of quinine?" That was not the object of presenting this paper; it was merely to caution those physicians who use quinine that visual loss might result, where the patient has an idiosyncrasy to the drug. Millions and millions of patients have been treated with large doses of quinine and we find only a few who have this idiosyncrasy.

I have been particularly interested in the possible prenatal effect of quinine, and feel that I have found two cases in infants who have a definite optic atrophy resulting from the prenatal use of quinine; that is, the use of quinine in a pregnant mother. I reported these two cases at the meeting of the Southern Medical Association, in November, 1935.

This baby that Doctor Holloway showed in the moving picture was also seen by me. Doctor Holloway brought him to my office a few hours after it was felt that the child could not see. The nerve head was not particularly pale, but there was a slight attenuation of the retinal vessels. However, this particular patient has been followed, and since that time there has been an increase in the paleness of the nerve head and an increase in attenuation of the retinal vessels. I feel that this is an important observation because I believe that if we will note the fundus in these quinine amblyopia cases shortly after the drug has been taken, we probably will see a nerve head at once that does not particularly impress us. I think paleness of the nerve head increases as time goes on as does the attenuation of the blood vessels.

Experimental observations on dogs who had massive doses of quinine show that the more important changes in the retina have been in the ganglionic layer and that the contraction of the blood vessels is a secondary effect.

I have three slides I wish to show:

In the first case I was called on the long distance 'phone by a doctor who stated that the patient had been brought in some six or eight hours after having taken 60 grains of quinine for the purpose of producing an



abortion. Doctor Zeagler of Palatka immediately recognized the condition as being that of a possible quinine amblyopia. The patient was more or less prostrated and in his hospital at the time. Suggestions were made as to the treatment of this particular case and I did not see the patient for several days. When the patient came to my office this plotting of the visual fields was made, which shows a very marked contraction of the peripheral field and considerable loss in color fields. The next slide depicts the visual field plotted some two and one-half years later. There had been some increase in the visual field. This patient's fundus showed a typical white nerve head and marked attenuation of the vessels. When I first saw the patient the pupils were widely dilated, but as time went on the pupils returned to normal.

The next slide shows a case in a woman who had taken quinine over a long period of time combined with arsenic. In this particular case the dosage of quinine was not particularly large but there was a very great loss of vision, the vision being reduced to hand movements. This represents the field of vision, there being no color vision present.

I think it is important for those members of the profession who administer the valuable drug we know quinine is, to understand the possible effects. Quinine may be ruinous to the vision and particularly to the fields of vision, for these peripheral conditions constitute a most important loss. In many cases the central vision returns to normal.

I think Doctor Holloway is to be commended for this excellent paper because it brings to all of us a very practical phase of medicine.

*Dr. L. L. Whiddon, Ft. Pierce:*

Sometimes in order to get interested in a subject there is a something that might happen to you to create this interest. I was sued once for \$30,000.00 due to this condition of quinine amblyopia. Doctor Richardson saw the patient I refer to. However, I am sure her amblyopia was cleared up long before the case was settled. She still complained when the case was settled but immediately afterward her sight became all right!

The essayist tried to bring out the fact that there are only a few cases of this condition due to an idiosyncrasy to the drug. This I admit, but after you get interested in it as I have, and after you give as much quinine as I try to give, (will say that I have given as high as 176 gr. per day to a patient) very large doses in many cases, it appears to me that there is an idiosyncrasy in almost all cases. I heard Doctor Robert Blue in Chicago say that where a person was sensitive to it, one grain a day would produce the condition.

Since becoming interested in this subject, I now test the field of vision in practically every case where I want to give quite a lot of quinine. The first day or two after I start the quinine I examine the field of vision. You will be surprised how many cases you will have of constricted vision from giving quinine. Out of the very small amount of experience I have had with it since I have been doing that, I have found about 40 per cent of the cases with restricted fields. That does not stop me from giving quinine, however. I give it if the field of vision does not continue to get less. If it continues to get less, of course I stop. Sometimes you can give it again in the course of two weeks or one month, and you will have no restriction of vision. Now, I don't know why that is. I have done that and you, by a very simple test, can test your field of vision after starting your quinine. In cases where you have to give quinine, it is a mighty good thing to know that you can test it in a day or two and know whether you are going to have trouble. Just test your field of vision. I think 40 per cent of the people are sensitive to quinine in that way.

*Dr. L. W. Holloway (concluding):*

Dr. Harry Mosher, in his presidential address to the American Otological Society at its last meeting in Boston, reported his findings after one year's study on the toxic effect of quinine on the fetus. From results of his study he concludes that the idea as originally promulgated by Dr. H. Marshall Taylor of Jacksonville, Florida, is true, as regards the toxic effect of quinine on the immature organs of the fetus.



## ABDOMINAL AUSCULTATION\*

J. H. Pound, M.D.,  
Tallahassee.

The efficiency of physical diagnosis is necessarily dependent upon a rational consideration of all factors having a diagnostic value.

Auscultation of the abdomen is a neglected method of investigation which should be regarded as an essential step in the examination of any acute abdominal condition, whether it be of surgical or medical nature.

As interns and medical students, some of us had called to our attention the metallic tinkle heard with the stethoscope in the distended abdomen of advanced intestinal obstruction. This was about the extent of the teaching of abdominal auscultation a few years ago. The English have attached much value to this diagnostic procedure as is shown in Vol. I of Maingot's *Postgraduate Surgery*.

At the Cook County Hospital in Chicago where there is a vast amount of material for the study of abdominal auscultation, Doctors R. T. Vaughan and Phil Thorek have made many interesting observations on this method of diagnosis. While a student at the Cook County Graduate School of Medicine the latter three months of 1936, it was my privilege to accompany these gentlemen on ward rounds of surgery and see this procedure demonstrated and conclusions verified at operation.

Many factors vary the normal rate of peristalsis: the proximity to meal time; the smell, sight or taste of food; hunger or fasting; and the recent use of a laxative or cathartic. Generally it may be said that the normal peristaltic rate as heard on auscultation is about the same as that of the normal pulse rate.

The normal peristaltic sound has been described as a muffled gurgling nonmetallic click, almost continuous. The clicks can be separated, although one sound goes into another with an occasional loud peristaltic rush. When one becomes cognizant of the tone, intensity and rate of the normal intestinal sounds as heard with the stethoscope, abnormal intestinal sounds are easily recognized. In certain acute abdominal conditions peristalsis may be in-

creased (hyperperistalsis); and in others decreased (hypoperistalsis).

Other abnormal sounds that may be heard on abdominal auscultation are: the rubbing together of inflamed peritoneal surfaces; a bruit over an abdominal prominence or tumor produced by an aneurysm; borborygmus over an abdominal prominence which indicates its connection with intestine or stomach; heart sounds—the more distended the gut the louder the heart sounds come through.

When a person has a gastric or duodenal ulcer, blanches and shows signs of hemorrhage, if the bleeding is into the stomach or lumen of the intestine, peristalsis is increased, continuous and noisy; if rupture of the ulcer has occurred and bleeding is into the peritoneal cavity the abdomen is quiet on auscultation. The latter is also true when the ulcer ruptures with or without hemorrhage, but with the stomach or intestinal contents leaking into the peritoneal cavity. In rupture of a form fruste ulcer there is not necessarily a change in peristalsis since no fluid or contents of the stomach leaks into the greater peritoneal cavity.

Cokkinis states that abdominal auscultation is very helpful in the early diagnosis of obstruction. Shortly after the onset of a mechanical obstruction the intestinal sounds are more frequent and louder than normal. Peristaltic rushes can be heard increasing in intensity as the site of the obstruction is reached, where an explosive sound may appear to occur.<sup>1</sup> There is no gas normally in the small intestine and as the obstruction progresses and the intestine becomes more and more distended, peristalsis is absent and an occasional tinkling, metallic click is heard; finally when gangrene develops the abdomen is quiet.

It is stated by Cokkinis that should the obstruction be high in the small gut where the distention is limited to the epigastrium there is little or no evidence of hyperperistalsis early; lower small gut obstruction presents hyperperistalsis early.<sup>2</sup> In obstruction of the large intestine there is marked hyperperistalsis, which can often be seen and heard as well as felt.<sup>3</sup> In this condition the cecum bears the brunt of the distention and may dilate to an enormous size; loud splashes may be heard over it on auscultation.

\*Read before the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, Tallahassee, Oct. 21, 1937.

The diagnosis of typical strangulated hernia is not difficult as a rule. However, atypical varieties such as epiplocele and Richter's hernia are often extremely difficult. The hernial protrusion is so small that it is likely to be missed and in some cases it is absent. This is especially true in obese women. The obstruction is partial and the symptoms are often inconclusive. There are two useful signs in such cases: one is increased peristalsis; the other is tenderness of a hernial aperture, usually the femoral canal. Cokkinis states that Richter's hernia occurs in more than 10 per cent of strangulated femoral hernia.<sup>4</sup>

It is well known that forcible taxis in reducing hernia has dangers, yet how many of us have not reduced a strangulated inguinal hernia by taxis when a patient has obstinately refused surgery; on occasions when surgical facilities were not available; or when the financial condition of the patient would not permit hospitalization. After reduction of the hernia the question arises as to whether a gangrenous gut has been reduced or an intestine ruptured. Often this doubt can be removed if on auscultation of the abdomen peristaltic sounds are heard to return.

Occasionally a portion of intestine which has been strangulated and whose viability is questionable will be returned to the abdomen. There is then quandary of whether a resection should have been done. In such cases the return of peristalsis as ascertained by abdominal auscultation produces a happy tickling of one's optic thalamus and enables one to know that after the first 24 hours intestinal peristalsis should be carefully encouraged by intestinal stimulants.

Auscultation of the abdomen for peristaltic sounds postoperatively is of assistance in determining what is going on. A very common sequel to any major abdominal operation is weakening of abdominal peristalsis, so-called protective ileus, which usually clears up before the third postoperative day. This grade of hypoperistalsis should not be regarded as unimportant since it might prove to be the forerunner of a paralytic ileus.

The moment a postoperative abdomen begins to distend the insertion of a Wangenstein duodenal suction tube is indicated. When and if the sounds of peristalsis begin to return, one may feel that the tube is doing much

good. If occasional gurgles and clicks do not return in 72 hours postoperative, it is suggestive that paralytic ileus has developed.

The return of postoperative intestinal movements signifies the time for purgation. Almost everyone has his own routine as to time and the variations are wide. The return of intestinal movements obviously vary with each individual case, dependent on the extent of the operative trauma, the degree of active infection persisting afterward, the irritation of drainage tubes, etc. As soon as protective ileus begins to pass off and intestinal movements are heard with a stethoscope, the signal has been given to encourage bowel movement by the routine favored. Before the return of peristalsis, purgation is useless, harmful and on occasions disastrous, as it may transform protective ileus into paralytic ileus.<sup>5</sup>

Cokkinis states that in postoperative paralytic ileus, the diagnostic sign is absence of peristalsis. At an early stage this silence may be limited to one region, but before long, particularly in peritonitic ileus, peristaltic sounds cease everywhere. Recovery is always preceded by the return of peristalsis, which should be listened for frequently. Soon after peristaltic sounds become audible again, flatus is passed, vomiting ceases, and the distention subsides.

As stated above, the diagnostic sign in an established postoperative intestinal mechanical obstruction is increased peristalsis which presents a striking contrast to the silence of paralytic ileus.

Although colicky pains and increased peristalsis in a postoperative patient usually means a mechanical obstruction, the picture may be altered by the presence or subsequent development of peritonitis. Another change is produced by the supervention of paralytic ileus, a mild degree of which may be present from the start.<sup>6</sup>

Auscultation of the abdomen is a valuable step in the diagnosis of diffuse peritonitis. Almost from the onset intestinal sounds are diminished and over the area of greatest involvement, they may be completely absent. This method of examination is often of assistance in differentiating early peritonitis from early mechanical obstruction.<sup>7</sup> In pelvic peritonitis due to the gonococcus there is little change, as a rule, in peristalsis.



Vaughan stated that a traumatic belly with normal peristalsis is not likely to have any serious injuries; also that the presence of a large amount of fresh hemorrhage after trauma to the abdomen will cause a quiet abdomen, though peristalsis may be diminished and yet no hemorrhage be present.<sup>8</sup>

Claybrook states: "Following traumatic rupture of the intestine the heart and respiratory sounds can be heard with a stethoscope all over the abdomen as clearly as they can be heard over the chest. The transmission of sound is due to peritoneal exudate."<sup>9</sup>

Thorek states that peristalsis in acute appendicitis is practically normal or slightly increased in the first six hours after onset unless the appendicitis begins with diarrhea; that if the appendicitis is obstructive in type and rapidly fulminating, peristalsis is decreased in a few hours due to early soiling of the peritoneum.<sup>10</sup>

When the appendix has become gangrenous, hypoperistalsis develops; after rupture resulting in spreading peritonitis, the abdomen is almost quiet on auscultation.

In a fasting abdomen with a slow, progressive, acute appendicitis when the patient has eaten nothing for several days, peristalsis is diminished. This also holds true in early appendiceal abscess.

In gastroenteritis and enteritis, peristalsis is usually markedly increased. This knowledge may assist in differentiating appendicitis and intestinal upsets. The return of peristalsis to normal may assist in determining when to increase the diet following gastro-intestinal upsets.

#### SUMMARY

I. Abdominal auscultation when used in conjunction with other methods of examination, history and symptoms included, is often of value in the diagnosis of acute abdominal conditions.

2. Hyperperistalsis is present in early intestinal obstruction; hypoperistalsis late in intestinal obstruction. In other words, the more severe the obstruction the quieter the sounds.

3. Hypoperistalsis is present in established paralytic ileus.

4. If gurgles and clicks do not return in 72 hours, postoperative, it is probable that paralytic ileus is present.

5. When blood, pus, fluid or exudate is present in the peritoneal cavity peristalsis is decreased. In other words "the wetter the condition, the quieter the sounds." This is particularly true in peritonitis.

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#### MALARIA\*

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Malaria is considered by many to be an old and trite subject on which the last word was said when the parasite and its mode of transmission were discovered. However, a great deal of work has been done and much of value has been learned, both experimentally and clinically, in the past few years.

Many consider that malaria is conquered—a thing of the past. Statistics reveal a different story. Sir Malcolm Watson says that it is responsible for more deaths than any other one disease. There are one million deaths from malaria annually in India alone. In Florida there were 445 deaths from malaria in 1934. In nine months of 1936 there were 453 deaths from automobiles, 1,033 from cancer, 659 from tuberculosis, and 217 from malaria. Think of the consternation that four hundred deaths in one year from poliomyelitis would cause. The death rate per hundred thousand from malaria in 1931 was:

Florida, as a whole, 21.6; Dixie County, 159.4; Citrus County, 107.1; Georgia, 15.2; Virginia, 0.62.

For 1926 the death rate from malaria per hundred thousand was: United States, 2.7; Europe, 3.6; Venezuela, 283.8; Canal Zone, 1.4. This last shows what can be accomplished.

\*Read before the Florida Midland Medical Society, St. Petersburg, Oct. 28, 1937.



Statistics show that Florida has a high death rate from malaria, but that many of its counties have no malaria. This is true of the counties. A small section of a county may have a very high death rate and the rest of the county be free from malaria. A small amount of money spent in the malarial sections would make many of the counties practically malaria-free.

Malaria is *not* always a mild innocuous disease, easily controlled. I have seen many patients die in less than twenty-four hours. I have seen them die before a doctor could get to them, and have known them to die on the way to a doctor. The monetary losses to the state from malaria are incalculable; the tourists that never come, the loss to the patient himself in time and money, the loss to his employer, the crops that are not made. The man with latent malaria, suffering from an anemic condition of the brain as well as the muscle, does not have much energy for either physical or mental work.

#### DIAGNOSIS

The first factor to be considered in the treatment of malaria is diagnosis. Malaria may simulate any known disease. Tuberculosis, appendicitis, and peritonitis are sometimes mistaken for malaria. Even cancer of the lung has been treated as malaria for four months. Pyuria is frequently diagnosed malaria. The cerebral form is sometimes mistaken for meningitis, encephalitis, or apoplexy. The history is an important aid to diagnosis, but a patient with a past history of malaria, a rise in temperature, sallow complexion, large spleen, a leukopenia, no parasites found in the blood, was found to have pus in his thorax. In another case—a tourist with high temperature, a great deal of pus in the urine and a large prostate—there was no evidence of parasites in the blood until the sixth day.

A negative examination of the blood means nothing. The search should be continued, taking specimen after specimen. A leukocyte count is an aid, but a leukopenia is found in other diseases; and a leukocytosis is often found in the early stage of malaria; or a pus infection, primary or secondary, may increase the number of leukocytes. A specimen taken just before death may resemble one from myelogenous leukemia.

The therapeutic test means little. Frequently the patient would have recovered as quickly without quinine. If the patient gets well under treatment and you have not found the parasite, you can only say that he *probably* had malaria. The absence of parasites or the finding of only a small number does not necessarily mean a mild infection, but the finding of a large number is significant. The phagocytes play an important part in the patient's resistance. In a serious infection the leukocytes in a thick smear may be filled with parasites in all stages of digestion.

**STRAINS:** Besides the four species of malaria there are many subdivisions or strains. It is impossible to differentiate the strains with a microscope, but the symptoms and immunity produced, their virulence and their reaction to the specific drugs, are characteristic.

**TOXINS:** Stitt considers that the parasite produces at least three toxins, a hemolysin, an agglutinin, and a pyretic. The proportions of these toxins vary in the different strains.

**INCUBATION PERIOD:** (a) *Extrinsic, (in the mosquito)* at a temperature of seventy degrees, Fahrenheit: tertian, 16 to 18 days; estivo-autumnal, 20 to 22 days.<sup>1</sup>

Boyd, Stratman-Thomas, and Kitchen have not found the mosquitoes bearing the vivax sporozoites to be infectious more than fifty days; nor the falciparum mosquitoes more than 40 days, after the completion of the extrinsic incubation period; and not at all reliable after more than 30 days and 20 days respectively.<sup>2</sup>

(b) *Intrinsic, (in the patient)*. Tertian: This parasite appears in the blood eight to twenty-three days after the patient is bitten. Fever usually follows a day or so later.<sup>3</sup> Estivo-autumnal: This parasite may be found from the sixth to the twenty-fifth day. The clinical onset is usually on the twelfth.<sup>4</sup>

**RELAPSES:** Where malaria is endemic it is rarely possible to say whether a patient has a fresh infection or a relapse. Physicians who are able to follow their cases closely claim that in a large percentage there are relapses, no matter what drug is given. The relapse may occur within a short time or if may be months afterward. Most malariologists believe that the parasites die out in two or three years, but Korovitsky claims only forty per cent have recovered in four years. It is as

difficult to determine when a patient is cured of malaria as of syphilis. Eventually the Henry test may enable us to do this. The inability to find the parasite in the symptom-free interval means nothing. Some malariologists believe that the parasite exists in a form not recognized. Others believe that it is present in its ordinary form but restrained in numbers and virulence by the resistance of the patient.

Anything that lowers the resistance, such as trauma, exposure, or childbirth, may cause a relapse. The real test of a drug is its ability to prevent relapses. So far the perfect drug has not been found.

**IMMUNITY:** Some patients seem to develop a real immunity. No parasites are found in their blood, but they cannot be infected by the same strain. Others have only a tolerance, that is, they have parasites in the blood, but no symptoms. In tertian malaria immunity to the same strain may last for several years.<sup>5</sup> In estivo-autumnal, this homologous immunity lasts as long as four months after the infection appears to be eradicated.<sup>6</sup>

It is almost impossible to produce fever in the negro with a tertian infection. Even though the tertian is found when he has fever, if the search is continued, the estivo-autumnal is usually found to be the real offender.

In endemic areas some believe that it is not wise to interfere with the fever unless it becomes too severe, but rather to allow the patient to develop his immunity. But many die before this is established.

In treating malaria it is important to consider everything that may lower the patient's resistance—unhygienic surroundings, the liability to infection by other strains, and diet. Improper food may not only lower his resistance directly, but indirectly by bringing on other diseases such as pellagra. Other infections—e.g., hookworm, frequently play an important part in the lowering of resistance.

**THERAPEUTICS:** Quinine is efficient against all forms of the tertian parasite except the sporozoites, but probably has most effect on the large schizonts.<sup>7</sup> It has no effect on either the sporozoites or gametes of the estivo-autumnal form. In other words, thirty grains of quinine a day before and for several days after being bitten by infected mosquitoes, will *not* prevent malaria. Neither will it pre-

vent infection of the mosquito that bites a patient who has estivo-autumnal malaria. Quinine does not act directly on the parasite, but probably on some organ or cells of the body causing the formation of something that will destroy the parasite.<sup>8</sup> The parasite will live in vitro in blood containing a one to five thousand solution of quinine,<sup>9</sup> whereas ten grains of quinine given every four hours—sixty grains a day—will cause a concentration of only twelve milligrams per liter in the blood,<sup>10</sup> i. e., a solution of twelve parts to one million. This concentration varies somewhat with the individual.

Quinine may be administered as follows:

1. By mouth: in capsules, suspension, and in solution. If the patient is nauseated and unable to retain anything, usually a hypodermic of morphine, one-fourth grain, or sometimes adrenalin, will settle his stomach sufficiently for him to retain one dose of thirty grains in solution. This is usually sufficient for the day. The next day he is usually much better. If the patient is a child, three drops of a solution of the bimurate, one grain to the drop, may be placed on his tongue where it will be readily absorbed. The quantity is too small for him to spit out. This is used only when he is unable to retain the more palatable forms.

2. By rectum: Sometimes, if the patient is nauseated, it is advisable to give the quinine either in oil or water by rectum. This is advantageous when the patient lives some distance from a doctor.

3. Intravenously: I think this should always be reserved for the very severe forms—e.g., the comatose—and occasionally where there is a great deal of vomiting.

4. Intramuscularly: This method is rarely justifiable on account of the danger of abscess. Probably it is often not absorbed. Most malariologists have discontinued the long courses of quinine.

#### ATABRINE

Atabrine, like quinine, destroys all forms of the tertian parasite except the sporozoite.<sup>11</sup> James claims that it does not destroy the sporozoites, but he has seen it prevent their development for thirty-three weeks. It affects the small schizonts first and the gametes last. It has no effect on the gametes of the estivo-autumnal strain. Its action is



probably a chemical one as it can be detected both in the serum and in the corpuscle and seems to have an affinity for the parasite. It is known that atabrin is retained in the body for long periods and continued excretion of the drug has been recorded for as long as two months after the last dose. It is not believed that it has a cumulative effect even though given every week for a year.<sup>12</sup> The foods which contain a large quantity of milk or cellulose take up atabrine, and prevent its absorption. The yellow tint which is sometimes observed in the skin is due to atabrine that, according to Peter, has been removed from the circulation and is not effective. Its toxicity is very low. Occasionally it causes cramps in the intestines, though these may not occur until the drug has been discontinued. They are easily controlled unless plasmochin has been given with it. Then they may become very severe, resembling a perforated duodenal ulcer. A few deaths have been reported from the combination. Plasmochin may be given to destroy the gametes five days after the atabrine has been discontinued. There is no objection to giving quinine and atabrine together in a severe case. Atabrine is practically insoluble. It should never be given in suspension as it tends to undergo chemical changes with a diminution of its activity.<sup>13</sup>

Reports from many parts of the world seem to prove that atabrine is slightly more efficient than quinine especially in preventing relapses. In some places quinine seems more efficient, in others atabrine, due possibly to different strains. On account of its slow elimination, it is possible that atabrine has a more prolonged action than quinine. In Manatee County quinine usually acts much more quickly than atabrine. In most reports on relapses, the cases have not been observed long enough. Relapses sometimes occur a year or more later. Then, too, we must not forget that there are not only seasonal but also yearly differences in the prevalence and virulence of malaria.

Plasmochin is said to affect the gametes and probably the sporozoites, thus supplementing the action of atabrine and quinine. It is usually given, not for its effect on the patient, as the gametes do not seem to harm him, but to prevent the mosquito from becoming infected and inoculating others. Col. James claims that it is more efficient than

either quinine or atabrine as a preventive, but that it is too toxic to take for a long period. Swellengrebel reported that it did not prevent infection, but only delayed the action of the parasite. He claimed that in one case fever developed as late as seven months and eighteen days after treatment.

#### CONCLUSIÓN

Malaria is worthy of serious consideration. It causes great loss of life, health, energy, and money. It is not a disease that lasts only a few days; frequently it lasts for years. There is still much to be learned about it, especially concerning immunity, relapses, and strains. The fact that there are different strains explains the conflicting opinions as to the efficacy of the different drugs.

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*Professional Bldg.*



## PERORAL ENDOSCOPY\*

### REPORT OF CASES

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Peroral endoscopy according to Jackson, is the term applied to endoscopic examination of the larynx, tracheobronchial tree, hypopharynx and stomach. The widespread interest and development of this form of examination are due to general progress of medical science and, as Jackson states, because "look and see" is the order of the day.

The endoscopist now makes the third of a diagnostic team. The internist can tap and listen to the outside; the roentgenologist can, in a sense, look through the patient; and the endoscopist looks into the individual and thus becomes an assistant in the same sense as the cystoscopist aids the renal surgeon.

The instrumentarium for endoscopy necessarily falls into the fundamental laryngoscopes, bronchoscopes, gastroscopes, and esophagoscopes with the secondary forceps, hooks, etc., that are many and often varied for the individual case. Of recent date, Jackson, because of the demands of the thoracic surgeons, has added a pleuroscope. This instrument is used to visualize empyemic cavities and aspirate them, break up adhesions that interfere with artificial pneumothorax, etc.

It has been my experience that anesthesia for endoscopy should be preliminary morphine and atropine hypodermically with local applications of pontocaine to the pyriform fossae for doing away with the gagging reflex through anesthesia of the superior laryngeal nerves. In children morphia should be given only to the older group and then sparingly. Ether is used occasionally in refractory cases. After exposure of the larynx in bronchoscopy, pontocaine or cocaine is applied directly to the larynx and trachea. With adults no anesthesia is used topically for esophagoscopy.

The best position for the patient is the dorsal recumbent with the head elevated above the level of the table in order to make the buccal cavity and pharynx in a straight line as the axes of the trachea and esophagus follow the curves of the cervical and dorsal spine.

Extension of the head is made at the occipito-alantoid joint. I encountered much trouble in using Rose's position with sand bags under the shoulders with the head lowered, making it next to impossible to introduce a rigid tube into the lower air or food passages.

With the proper position, the laryngoscope is introduced, the epiglottis is elevated by the scope and the larynx is seen. The Jackson tube is then inserted through the laryngoscope and the latter withdrawn. If esophagoscopy is to be done, the orifice is located and the esophagoscope inserted. Through the tube the pathology or foreign body is located and visualized. Jackson advises that in every foreign body case the procedure be tried first on a manikin, using a duplicate of the foreign body, before actual removal is attempted. Also every patient should have roentgenologic study from the nasopharynx to the crest of the ileum in order that multiple foreign bodies be not overlooked.

Foreign bodies require study as to the best type of forceps suitable for their removal and hence the preliminary study on the manikin. If pathology is demonstrated through the tube, a portion can be removed with punch forceps for microscopic study or the growth can be removed at this time with some of the basal tissues, if small.

Endoscopic work is very dramatic and yet requires considerable skill. It is a specialty within a specialty. In the smaller centers with few cases and equipment that cannot compare with that of the larger clinics, allowances must be made for the work that someone must do, as it is often life-saving and of an emergency character. However, it is important that no one doing this type of work be rushed into performing an operation without the necessary careful preliminary examination and study which so often spells the difference between success and failure.

I think it wise to call to your attention the variance in foreign body cases and to have you note that the vegetable aspirations into a bronchus are of much more concern than metals or other inanimate materials. Vegetable foreign bodies, such as a peanut or bean, must be removed immediately because of the terrific tissue reaction that is set up within the air passages which rapidly becomes fatal. Two such deaths occurred in my practice.

\*Read before the Escambia County Medical Society, Jan. 11, 1938.

The cases I am presenting have a general appeal and were all successfully treated endoscopically. These are all foreign body cases and no mention will be made of esophageal strictures and others which have been treated.

#### CASE REPORTS

Case 1. J. G., a 2½ year old boy, was treated by his family doctor for three months for intestinal influenza. Finally, when there was no improvement, he was referred to a local pediatrician. The child was taking only liquids and refusing all solid foods. I was requested to do an endoscopy for a possible diagnosis of esophageal stricture. Fluoroscopy with barium was suggested for diagnosis instead of endoscopy and when this was done a round object the exact size of a twenty-five cent piece was found at the cricoid constriction of the esophagus. Endoscopy was advised and when the scope was passed, the child collapsed and stopped breathing immediately. Resuscitation was done and the patient put back to bed. As there was no thymic enlargement rectal feeding was instituted for three days. A second operation was done without mechanical difficulty but the foreign body could not be visualized. Under the fluoroscope the tube was put against the foreign body and still it could not be seen through the tube. We then knew that folds of mucous membrane pocketed the foreign body and decided to allow the patient to rest 24 hours and do a third operation. On the third attempt, bouginage was done through the tube until the quarter finally dropped from its recess and was easily removed. The patient had no trouble, began eating as soon as solid food was allowed, and made a rapid and uneventful recovery. No anesthesia was used at any time.

Case 2. This 2½ year old patient was brought in with a diagnosis of a nickel in the esophagus. The child had been unable to swallow anything, even water, for one week. The father took it to a general practitioner who suspected a foreign body and had an x-ray made which demonstrated the body at the cricoid constriction of the esophagus. When I told the father that he would have to take his baby to the hospital he refused as he had been angered by the refusal of the x-ray department to give him the x-ray picture. He took the baby to a nearby small town where an unsuccessful attempt was made to remove the foreign body under ether. The father was advised to take his child home and allow it to die as nothing more could be done. The baby was immediately brought to the hospital as a last resort. Ether was again administered because of the restlessness and trauma from the previous manipulation, and the nickel removed in ten minutes. The coin was endwise in the esophagus, completely corking it, with no grasping surface and had to be turned through the tube by placing a metal probe against the lower end and doing a version. After two hours, cracked ice was given and later milk, which liquids were carefully administered because of the starvation period. The child made a rapid and uneventful recovery and, in spite of the trauma and exposure immediately after ether anesthesia, the temperature did not rise to more than 100° F. Two days after the esophagoscopy the child was eating soft foods and after three days was on a general diet.

Case 3. G. W., a 7 months old colored girl, was brought to the office with a history of having swallowed a safety pin just a few hours previously. An x-ray made at the hospital showed the pin, point up, at the aortic constriction of the esophagus. Esophagoscopy without anesthesia was done but the pin was not located. Fluoroscopy showed that the pin had slipped down to the cardiac constriction and it was discovered that the mother had given the child milk after the first x-ray and before the operation without our knowledge or consent. The tube was reinserted and the pin located.

The point had made no perforation and there was very little trauma. The point was brought into the end of the tube and the pin removed without closure as the rounded keeper would not traumatize on exit. The child made a rapid and uneventful recovery.

Case 4. The case of J. B., 14 months old, is of particular interest as the diagnosis was made from history. The mother brought the child to the office because he wouldn't eat and hadn't eaten for four days. There was no throat pathology, the temperature was normal and there were no general signs of illness. A more detailed history was elicited with the discovery that the complaint started from the time the child had been placed in a box of wood and given a jelly-coated piece of bread to eat while the mother was at her work. The deduction was made that the child had dropped the bread with the sticky jelly, picked it up with a piece of wood clinging to it, and then ingested it. The piece of wood was located at the middle third of the esophagus and came away in crumbled pieces. The child had no postoperative trouble and the recovery was spontaneous.

Case 5. J. G., a colored male, aged 40, was referred from out of the city, complaining of having swallowed a Coca-cola top after opening the bottle with his teeth. X-ray showed the bottle top at the aortic constriction of the esophagus and it was easily removed without anesthesia.

Case 6. D. R., female, eight years old, was brought to the office complaining of hoarseness and pain in the neck, with a history of aspirating a sandbur. Mirror laryngoscopy showed an imbedded bur in the anterior commissure of the larynx. Without anesthesia, the scope was introduced and the bur removed. There was no laryngeal edema subsequent to the removal and the child made a rapid and uneventful recovery.

Case 7. This case is presented to stress the frequency with which children put sandburs in the mouth. M. F., female, aged 10, put a sandbur in her mouth, started to laugh, and aspirated the bur. The removal was the same as in Case 6.

Case 8. Mrs. J. S., 34 years old, swallowed a straight pin which she had held in her mouth. A picture showed the pin in the upper esophagus. The esophagoscope was passed and the pin, which seemed to have made no perforation, was easily removed. The patient made an uneventful recovery.

Case 9. In the case of Mrs. McC., a fishbone had lodged in the esophagus. This was removed and the patient made a rapid recovery.

Case 10. Mrs. J. D. The extraction of a hairpin presented a problem of two points. One point of the pin was bent in and the other sheathed in the tube.

Case 11. Mrs. C. O. B., aged 52 swallowed a chicken bone while drinking soup. The bone was removed from the cricoid constriction of the esophagus.

All of the foreign bodies mentioned in these case reports have been mounted for your inspection. It is worthy to note the extreme discoloration of the quarter and that the paint has all been removed from the Coca-cola top by internal secretions.

With constant practice on the manikin and the development of a team, it is hoped that more efficient work can be done along these lines.

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## THE FINAL RESPONSIBILITY OF PUBLIC HEALTH RESTS ON THE MEDICAL PROFESSION\*

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The early history of the public health movement definitely places it in the ranks of the medical profession.

The early history of the American Public Health Association reveals that prominent practitioners of medicine and surgery furnished the guiding hand, and for many years this organization listed a predominant part of its membership from the outstanding physicians of the country. The Year Book for 1904, seven years before the first county health department was organized, quoted from the *Lancet*, July 11, 1903, that T. S. Clouston urged the importance of a health apostolate "which shall devote itself to the public health as the evangelist does to the salvation of souls. \* \* \* We sadly need an organization for our propaganda and some authoritative body with continuous life to attend to the soundness of our people in body and mind." The Year Book further comments: "The medical profession should aim to control education in the interests of health and to institute a propaganda for health which would instruct the people upon all the health problems which have arisen in modern life and establish a health conscience." It further states that this can be attained by organized action of the medical profession through the use of the public press, lectures, tracts, by the distribution of health primers among the people, and the employment of trained workers for the dissemination of health education.

In this same volume is expressed the need of concentration of authority in Boards of Health. It deplores the numerous unskilled agencies that are dabbling with health matters. "A Board working on such a basis and with all the duties and authority in it, instead of being diffused over an indefinite number of persons could control epidemics and gather materials for statistics and conclusions which would be valuable. Under the present system such statistics are without value and cannot

be taken as the final factors in determining the origin, development and progress of disease." Teaching of hygiene in the schools, physical examinations for children, immunizations, prenatal and postnatal care, and much the same discussion for the control of venereal disease which one now hears. All this attests that the medical profession was and is alert to the situation. They are irked by such statements as the one which recently appeared in the *Literary Digest*: "Government must assume a new responsibility, and the medical profession must modify its rugged individualism and cooperate with government." This is typical of the lay attitude when they have suddenly been confronted with something new to them. They immediately assume that the profession is to blame and not the indifference of the people and the government to the admonitions of the medical profession. A great many people are apparently getting greatly agitated over something they have just found out, but which the medical profession has been preaching for years. The physician resents too much advice from unqualified sources. A little learning is a dangerous thing. Pope in his "Essay on Man" advises us to drink deep or stay away from the spring. The physician resents the non-medical doctor of public health interfering in programs involving medical questions. Vaughn of Detroit and Epperson of Durham are notable exceptions, but there are no health departments anywhere which work in closer cooperation with the medical profession than Detroit and Durham. It is obvious that any health officer regardless of how competent he may be is handicapped if he doesn't have an M. D. degree. He is never fully accepted by the profession with which he must work.

Public Health is a child of the medical profession. The question is: who shall assume responsibility of the rearing of this child? If you disclaim this responsibility either by an apathetic attitude or by open antagonism, it is obvious that your neglect of this paternal obligation is likely to result in the waif being adopted by misinformed, misguided, even though well intentioned laymen, or perhaps political interests which see only the opportunity for extension of the spoils system. It

\*Read before the Sixty-fifth Annual Meeting of the Florida Medical Association, held in Miami, May 9, 10, and 11, 1938.



is obvious that thinking people are going to recognize the advantage of sound programs of preventive medicine. The application of medical and sanitary engineering sciences to health problems are not only economic but humanitarian. The physician by precept, training, and experience is best qualified to pass upon the merits of a public health program. This is not guess work. There is the experience of Alabama, North Carolina, Mississippi and others to substantiate this fact. In these states public health and the medical profession are working as one for the betterment of the people and all groups are satisfied. In these states the profession has not only recognized its responsibility but has demanded that the responsibility be placed where it belongs. "To medical men belong medical matters" is an axiom stated by a prominent physician.

In one State where mismanagement by other agencies was very marked, the health department did everything except public health work, and statistics proved it. The politically-minded health officer went so far as to denounce the medical society from the platform, which reminds one of the story of the old lady who said all the soldiers were out of step except her son. This sort of thing made it appear that C. P. H. which is meant for Certificate in Public Health, can also stand for Confirmed Political Henchman.

By a hard fight the medical society was able to replace this officer with a soldier who kept step with the army, and indications are that much progress is now being made. Had the medical society evinced the same interest earlier this situation would not have arisen. By their failure to recognize the responsibility earlier, they had a distinct problem child on their hands who required drastic measures. The Florida State Board of Health has confidence in the Florida Medical Association and we are urging you to rear your child and not allow it to become a problem child. A problem child can only reflect discredit upon the parents. The responsibility is the parents' whether they want to accept it or not.

Public Health with few exceptions, past and present, has neither attracted nor produced the outstanding men of the profession. Unstable salaries, insecurity of tenure and limitation of movement are undoubtedly the

responsible factors. It is your duty to see that only the ablest and most ethical shall hold such positions, for despite the low financial returns this is one of the most important posts in any community.

Your State Board advocates full-time health service for every community in Florida. Florida has many part-time health setups which we do not recognize. The city or county physician we deem necessary as long as this physician, whether part-time or full-time, devotes his time to treatment of the indigent. He is fulfilling an important duty and is not likely to abuse the privilege. The part-time physician who also attempts to serve as health officer is in a position to use his office to further his practice. We recognize that many of these men are ethical and do not take advantage of their position, but, nevertheless, the opportunity is there, and there have been rumors of unethical practices. The State Board does not believe in subsidizing a man to compete with his fellow practitioners. Doctor Parran, in commenting on the health officer, states: "A third and most important standard is: does he devote his full time to his health job, or is that a side issue to his major interest of private practice? Every sizeable community needs the full-time, whole-hearted interest of a well-trained health officer." Therefore, we insist on the full-time setup directed by a physician trained in health administration, and who is not motivated by a desire to practice medicine. This removes any incentive for unfair tactics.

The State Board of Health is attempting to organize adequate local health service in every community in Florida. In order to do this we must have the support of the medical society in these counties. The results in counties where we have units confirm the efficacy of this setup. We have the support of the Florida Medical Association and the support of the county societies in the counties in which there are units.

The county medical societies in Manatee, Polk, Alachua and Lake counties are ardent and enthusiastic in their efforts to establish units in their counties. It is felt that their enthusiasm is undoubtedly based on a thorough understanding of the setup, and that other component societies will follow when they are better acquainted with the idea. That

the various communities sooner or later will demand some type of health setup is inevitable. That the medical society should take the lead in this matter is undeniable and it should take it early enough to preclude the possibility of any lay groups or agencies attempting to usurp control. The State Board favors close cooperation with medical societies because experience has shown that the best interests of the public are served by this method.

There are such things as non-medically directed health departments. The medically-directed health department sees and appreciates the physician's viewpoint and will certainly be more cooperative than a lay-controlled organization. Are we, as physicians, going to assume the leadership or shall we supinely sit down and let other agencies dictate the policies? No doubt there are lay groups desirous of getting control of public health and they are not particularly concerned as to what is for the best interests of the people.

The activities of the health unit with its maternity conferences mean more deliveries by physicians and fewer by ignorant midwives. Following an immunization campaign by the health department the private physician does ten immunizations for every one that he did prior to its popularization by the health department. School examinations, calling the parents' attention to defects, result in increased work for the physician. It is through health education that the department renders its greatest service. The health unit can furnish for Medicine the organ of propaganda suggested by Clouston in 1903. Medicine and public health have nothing to fear from the truth. If they did, neither would deserve to exist. Through health education teach the public to demand service and to pay for it. The public is eager for medical information. If we do not supply it, they accept misinformation from cults and charlatans. Education of the public must ultimately mean development of public opinion, which will produce legislative limitations, if not abolition, of cults and quackery which wax fat on the ignorance and superstition of the public. The family physician should be the health officer for the families whom he serves. He should see that they receive the necessary immunizations,

tests, periodic examinations, corrections of defects as well as treatment for the acutely ill, and refer them to the specialist when necessary. This is not only his right, it is his duty! The ethical and conscientious health officer is the physician's greatest ally. Fifty-two counties in our State have no health setup at all or a type that is scarcely worth mentioning, and this type rather impedes than aids in the march of progress.

There are a few part-time physicians and health officers who have some selfish motive which renders them impervious to any argument that might be advanced, yet who are sufficiently entrenched to thwart the program insofar as their individual counties are concerned. They give to their counties setups which do as they see fit and rarely, if ever, consult with the medical society regarding policies. The State Board could probably place units, regardless of the county physician or the apathy of the medical society, were it so inclined. It is unlikely that any Board of County Commissioners would refuse government money if it was offered to them with no strings. If the Board would scrap the requirements for special personnel, deviate from recognized and accepted policies and otherwise "play ball" with the local politicians, there would undoubtedly be more counties which might be listed as full-time cooperative units, but the answer of the Board of Health is that unless it is to be a worthwhile unit, the local governing body can continue to pay the bill and assume full responsibility for the waste.

There seems to be a rather dubious attitude on the part of the profession regarding the drive against syphilis. That many of these patients are indigent and must be handled just as indigents suffering from any other cause is plain. In his book, *Shadow on the Land*, Doctor Parran says: "It is for these reasons that I have continued to urge upon the physicians of this country a middle way, which, I believe, would avoid the evils they fear of regimented medicine and the evils I fear of uncontrolled disease. If private charity and united professional enterprise fail to provide for all the protection of medical science, it is inevitable that such protection will be demanded from the State, and to a greater degree than most of us, whose business it is to



administer health functions, believe to be either wise or necessary. Such treatment is impossible for many men and women not indigent who would be willing to pay an occasional doctor's fee; who would prefer the service of a good private physician to the clinic at its best, and who infinitely prefer it to the hurried, crowded, not too careful, inconsiderate services of those public clinics which are far from the best."

Clinics for the indigent operated by the medical profession and supervised by the health department have been in operation for years in many other states and one rarely hears mention of so-called state medicine in those states.

It is doubtful whether simply treating syphilis will eradicate the disease, but treatment along with a sustained educational campaign will work wonders. The advisability of free treatment for all cases is questionable. There is no reason why those capable of meeting the cost should expect the government to pay it for them. There should be legislation strict enough to enforce treatment at the victim's expense when it is obvious he is financially solvent.

Treatment is not in the province of the health department. Frank indigency can be handled only through a charity clinic conducted by the medical society and the health unit, and there should be a thorough investigation of all cases. How can any of this be accomplished without a full-time health unit working in cooperation with the medical profession?

An increase in the number of Wassermann or Kahn tests done by the health department will result not only in an increased number of patients for treatment in the private physician's office, but will result in his taking more blood specimens as well. The health unit increases the doctor's income by popularizing the work. Health authorities have neither the intention, means, nor desire to encroach upon the field of curative medicine and, furthermore, are glad to give to the practicing physicians all the preventive phase for which they will accept responsibility; yet this nowise relieves the health department of its responsibility for the ultimate reduction of disease rates.

Socialized medicine is sometimes confused with public health by the uninformed. The functions of a well-organized health department can be covered by four words; all of its functions can be listed as educational, advisory, investigatory and legal. The conscientious public health man is just as much opposed to so-called socialized medicine as you are and, furthermore, does not even deem it a threat unless an apathetic attitude on the part of organized medicine should allow these medical matters to be transferred to lay hands, who see not prevention but treatment.

Dr. F. H. Smith, in his Presidential address to the Medical Society of Virginia in 1935, said that no physician does or should oppose anything on the ground that it will injure physicians. "If the interests of the private practitioner conflict with the common good, then both practice and practitioner are as dead as the proverbial dodo. \* \* \* Government control and such an intangible thing as the personal service of good medical care are simply a contradiction of terms. The one is incompatible with the other. No people can have both."

There has been much talk of medical treatment by the State, regimentation, health insurance, hospital insurance, subsidization and various and sundry plans for changing the economic scheme of medical practice, but no talk regarding methods of building up the fibre of those most likely to become the recipients of this treatment. When John Smith has ten children whom he cannot support with another on the way to further swell the ranks of indigency, then probably it is time to declare an overproduction of this particular species of Smiths. They cannot be plowed under because our civilization which permits them to starve, freeze, suffer from disease and otherwise exist in misery will not countenance control of the crop at planting time.

Undoubtedly if there were fewer of the people who demanded everything for nothing, this in turn would lessen the demand for State Medicine. Through health education organized medicine and public health should lead them from medical pauperization to a realization of their own obligations and duties. Such health education can best be promoted by a full-time health unit.



Our greatest menaces are within our own ranks:

1. The physician who is so misguided as to make remarks implying that a lack of typhoid fever and other preventable diseases is decreasing his income. Such a man, while greatly in the minority reflects no credit on the profession. He places the profession in a bad light before the public and yet he constitutes less than one per cent and then probably does not belong to the medical society.

2. Most governmental bodies recognize in some manner at least their obligations to protect the health of the community and in many cities and counties an attempt to carry out this obligation is manifested by the employment of a part-time health officer. Part-time officers may come under two classifications:

The first is the very busy practitioner of medicine, who more or less has it thrust upon him by the governing body and, in many instances, rotates his turn among his fellow physicians in attempting to share a responsibility which the Commissioners are attempting to unload in what appears to them, the cheapest manner possible. Naturally, this physician does not want the job. He is honorable and conscientious enough to recognize that he cannot give it the time it deserves and freely admits it. He simply accepts it because no other provisions are made. This man is one of the sincerest advocates of full-time health service.

The second type is usually a political factor in the community. Politics is his first consideration, practicing medicine his second and public health not at all. The part-time pseudo-health officer, who piddles with public health, is very jealous of his prerogatives and fearful that a full-time unit might interfere with the pension being allotted to him by the city or county while he competes with you. As far as constructive health work is concerned, he is a minus quantity, and statistical records substantiate the worthlessness of such arrangement, so much so that the State Board does not recognize it as being more than simply a health department in name, frankly harmful because it is responsible for a false sense of security on the part of uninformed people by leading them to believe that they have health protection when statistics show that they do not.

The County or Municipal Board which pays five or six thousand dollars per annum for part-time service, when especially trained, qualified personnel on a full-time basis is available at the same figure, is usually scratching its own back in a political way at the taxpayers' expense.

One county medical society went on record with the recommendation to its commissioners that they either consult the State Board of Health and put the work on as it should be or quit the pretense, abolish the quasi setup and save the money. In one instance a county medical society, after endorsing the health program, later rescinded its action due to the influence of the part-time county physician. Although there was a strong sentiment in the society for the unit, the part-time man was able to sway enough physicians by personal appeal to vote with him simply because they felt no desire for antagonism and being rather apathetic decided this was the line of least resistance. There are one or two other societies in the State that probably are confronted with the same situation. The attitude of the State Board is to let them work out their own salvation.

These menaces are responsible for the agitation of state medicine and, if uncurbed, might eventually bring such conditions upon us. Are such persons interested in the future of medical practice, the future of the people, or the future of anything except that monthly pension? They will gladly sell you out for a mess of pottage.

Gentlemen, do not let them lead you astray! What might look now like the line of least resistance may really be the hard road. Do not let them sacrifice medicine and public health upon the altars of their own greed and short-sightedness. By blocking the medically-controlled and medically-operated unit, they are paving the way for other agencies to eventually take it over. You could serve yourselves and the public in no better manner than the abolition of the part-time setup. Either make it full-time or not at all. The thinking people at least are aware of the existing conditions in such communities and are recognizing at least in some instances that the medical society is doing little or nothing about it.

Let me impress upon you that if we, as doctors, do not assume the responsibility,

other agencies will. Let me urge that you take a more active interest in seeing that your county has full-time health service.

The greatest threat of State Medicine is within our ranks. The answer lies with the physicians. Will we eliminate such a demand through adequate health service or do we intend to remain dormant until disease rates and insanitary conditions reach such inexcusable proportions that an alarmed public demands some type of setup from the State, which may lack necessary medical leadership to prevent it from falling into the hands of demagogues and crack-pots sponsoring policies very distasteful to the medical profession and disastrous to the people? Why experiment? Why fiddle while Rome burns? You are responsible for the type of health program in your State and County. You may say that you are busy practicing medicine and not bothering with public health at all, but that will not excuse you. You are the one who is presumed to know something about what constitutes an adequate program. Upon your brow will rest credit for a commendable program, or upon your shoulders will be the odium of a disreputable program. You will not be excused on the grounds of omission. You cannot pick up your marbles and go home and leave the field to mismanagement by unqualified agencies without injury to yourselves and irreparable damage to the public.

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*P. O. Box 210*

#### DISCUSSION

*Doctor N. L. Spengler, Tampa:*

I want to thank Dr. McCreary for his splendid paper. I read a paper before a medical society on economics on one occasion when Doctor McCreary was present. When he arose to discuss my paper, he said, "Doctor Spengler, your paper is a challenge to organized medicine." I want to say to you, Dr. McCreary, that your paper is also a challenge to organized medicine, plus an invitation and an assurance of good will and interest of the public health service in our welfare. We must admit that we do not possess the amount of public confidence we once did because we have lost 80 per cent of our public patronage. If we want this business restored, our friends

will have to help us, and I consider your organization one that we can depend on at all times to safeguard our interest, and help us to establish and perpetuate a program that will meet the demands of the public. We will do well to trust you at all times because if we do not cooperate, the future operation of medicine will be out of the hands of us both, and when this happens, may the Lord help both of us.

We cannot do the job before us alone and, as I see it, we must delegate the business side and organization and operation of the plan to you, where our interests will always be cared for in the best possible manner.

You have referred to the county health unit in cooperation with the local medical society. When you came to Hillsborough County and organized a unit in cooperation with us, you relieved our county of a conglomeration of overlapping agencies and set up a single organization that meets all the requirements, and our relation has been entirely satisfactory. In some instances you are too conservative. We should be permitted to treat these indigents, as well as diagnose their condition. I have worked in these clinics and know that it would go a long way to establish public confidence in us, because we have more time and can do a better job than an overworked, and in many instances a part time, health officer. Doctors entering public health work are better prepared and are doing better work than the old timer, and it will be to our interest to improve our service as well as the public health men.

The Public Health Service is cooperating with the federal government in solving our problems. As a result, they are going to receive federal aid in large figures, because legislative bodies can always hear the cry of their constituents. So the joint bill by Mr. Lewis now pending, and the one introduced in March by our own Mr. Pepper, will pass. We objected to Mr. Lewis' bill. I guess we will do the same to Mr. Pepper's bill. I insist that we should join with our closest ally, public health, who occupies almost the same position we do, since we have nothing better to suggest. I never knew any one to get anywhere objecting to everything and suggesting nothing constructive. Radical reforms are ahead

of us. Are we going to help control them or are we going to delegate the job to a bunch of mercenary laymen who know nothing better than political plunder?

Doctor McCreary warns us against the large number of lay agencies dabbling with public health matters. I guess he is too timid to say that these bodies of laymen are a menace to public health programs and that they could not exist without the support they get from the medical profession. I think we should promptly start to work on them by tendering our resignation to any office we hold in them and arrange to have this work done by skilled public health officials with our full support and cooperation with public health.

I saw the futility and danger of giving any service to assist lay organizations in public health matters ten years ago and since that time, I have steadfastly refused to cooperate with them though I knew a refusal meant boycott for me.

I am glad to know that the day for a showdown is here. I hope the medical men of America will cast aside their pacifism and meet the issue in the open. This is the only way we can win. We are daily confronted with fear among some of our medical men of socialized, state or regimented medical service. There is no danger of either of these plans winning if we cast our lot and influence with the Public Health Service.

It has been a pleasure to read and discuss Doctor McCreary's paper and I hope organized medicine will accept his challenge.

*Doctor M. M. Harrison, Bradenton:*

I consider the paper that Doctor McCreary has just read one of the most important that we have heard. Doctors have always been considered guardians of the public health. If we would be considered superior to the cults, we must do our best to warrant that regard.

"An ounce of prevention is worth a pound of cure." To me, the prevention of disease, especially in a child, is far more important than prolonging the life of an old person a few days or weeks. Disease frequently cripples the mind as well as the body, especially if prolonged over a long period of time. By

preventing disease in a child, we may enable him to become a useful citizen instead of the dead beat John Smith that Doctor McCreary mentioned.

Our citizens and our visitors have the right to expect the State to guard their health to the best of its ability. It cannot be done by these political organizations. In these days of rapid transportation it is as necessary for the health organization of a county or state to cooperate with the organizations of other counties and states as it is for the sheriffs' offices to cooperate. This cannot be done when each county has its own independent organization.

In Manatee County we had and still have one of these political organizations. Our medical society was very much dissatisfied. We investigated the health unit as designed by the Board of Health, cooperating with the U. S. Public Health Service. After satisfying ourselves that it had nothing to do with State Medicine, we decided to see if we could get a unit for our county. We thought that all we had to do was to bring it to the attention of the County Commissioners and show them that it was cheaper and more efficient than their plan; we were soon disillusioned.

Then we decided to appeal to the public. We did this by articles in the newspapers and by addressing the various organizations, such as the Chamber of Commerce, the civic clubs, and the P-T. A.'s. To the P-T. A.'s we emphasized child welfare and the work to be done in the schools; to other organizations, the necessity of pure food and water and the necessity of sanitation in the tourist camps. Then we called for a mass meeting to go before the County Commissioners. The court house was packed. After seeing the number of votes represented, three commissioners gave in. Two Commissioners remained obdurate but were outvoted and a contract was signed. But the two commissioners were still not defeated. They said they would accept the unit if we would accept their man as a sanitary inspector. We felt that if we allowed one man to be appointed on purely political grounds, soon all five would be, and the value of the unit would be destroyed.



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## SOCIALIZED MEDICINE AND POLITICS

Every member of the Florida Medical Association should familiarize himself with the recommendations of the Interdepartmental Committee presented at the National Health Conference held in Washington, July 18-20. These recommendations were published in the Journal of the American Medical Association, July 30, 1938, Vol. 111, pp. 432-454. The proposed program represents the Administration's plan to socialize medicine and thereby manipulate huge sums of money, primarily for the maintenance of a colossal political organization and, secondarily, for the nation's health. Five major proposals were made, namely: 1, expansion of public health service; 2, increase of hospital facilities; 3, medical care of the medically indigent; 4, a general program for medical care; 5, a program for compulsory sickness insurance covering the entire population of the United States.

A special meeting of the House of Delegates of the American Medical Association was held in Chicago, September 16 and 17. The National Health Conference proposals were studied by well-chosen committees. Their recommendations were approved by the House of Delegates and are as follows:

1. Under Recommendation I on Expansion of Public Health Services: (1) Your committee recommends the establishment of a federal department of health with a secretary who shall be a doctor of medicine and a member of the President's Cabinet. (2) The general principles outlined by the Technical Committee for the expansion of Public Health and Maternal and Child Health Services are approved and the American Medical Association definitely seeks to cooperate in developing efficient and economical ways and means of putting into effect this recommendation. (3) Any expenditures made for the expansion of public health and maternal and child health services should not include the treatment of disease except so far as this cannot be successfully accomplished through the private practitioner.

2. Under Recommendation II on Expansion of Hospital Facilities: Your committee favors the expansion of general hospital facilities where need exists. The hospital situation would indicate that there is at present greater need for the use of existing hospital facilities than for additional hospitals.

Your committee heartily recommends the approval of the recommendation of the technical committee stressing the use of existing hospital facilities. The stability and efficiency of many existing church and voluntary hospitals could be assured by the payment to them of the costs of the necessary hospitalization of the medically indigent.

3. Under Recommendation III on Medical Care for the Medically Needy: Your committee advocates recognition of the principle that the complete medical care of the indigent is a responsibility of the community, medical and allied professions and that such care should be organized by local governmental units and supported by tax funds.

Since the indigent now constitute a large group in the population, your committee recognizes that the necessity for state aid for medical care may arise in poorer communities and the federal government may need to provide funds when the state is unable to meet these emergencies.

Reports of the Bureau of the Census, of the U. S. Public Health Service and of life insurance companies show that great progress has been made in the United States in the reduction of morbidity and mortality among all classes of people. This reflects the good quality of medical care now provided. Your committee wishes to see continued and improved the methods and practices which have brought us to this present high plane.

Your committee wishes to see established well coordinated programs in the various states in the nation, for improvement of food, housing and the other environmental conditions which have the greatest influence on the health of our citizens. Your committee wishes also to see established a definite and far-reaching public health program for the education and information of all the people in order that they may take advantage of the present medical service available in this country.

In the face of the vanishing support of philanthropy, the medical profession as a whole will welcome the appropriation of funds to provide medical care for the medically needy, provided, first, that the public welfare administrative procedures are simplified and coordinated; and, second, that the provision of medical services is arranged by responsible local public officials in cooperation with the local medical profession and its allied groups.

Your committee feels that in each state a system should be developed to meet the recommendation of the National Health Conference in conformity with its suggestion that "The role of the federal government should be principally that of giving financial and technical aid to the states in their development of sound programs through procedures largely of their own choice."



4. Under Recommendation IV on a General Program of Medical Care: Your committee approves the principle of hospital service insurance which is being widely adopted throughout the country. It is susceptible of great expansion along sound lines, and your committee particularly recommends it as a community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that these plans should confine themselves to provision of hospital facilities and should not include any type of medical care.

Your committee recognizes that health needs and means to supply such needs vary throughout the United States. Studies indicate that health needs are not identical in different localities but that they usually depend on local conditions and therefore are primarily local problems. Your committee therefore encourages county or district medical societies, with the approval of the state medical society of which each is a component part, to develop appropriate means to meet their local requirements.

In addition to insurance for hospitalization your committee believes it is practicable to develop cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations to insure their soundness and financial responsibility and have the approval of the county and state medical societies under which they operate.

Your committee is not willing to foster any system of compulsory health insurance. Your committee is convinced that it is a complicated, bureaucratic system which has no place in a democratic state. It would undoubtedly set up a far-reaching tax system with great increase in the cost of government. That it would lend itself to political control and manipulation there is no doubt.

Your committee recognizes the soundness of the principles of workmen's compensation laws and recommends the expansion of such legislation to provide for meeting the costs of illness sustained as a result of employment in industry.

Your committee repeats its conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitalization and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

5. Under Recommendation V on Insurance Against Loss of Wages During Sickness: In essence, the recommendation deals with compensation of loss of wages during sickness. Your committee unreservedly endorses this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and of recovery, which function should be performed by a qualified medical employee of the disbursing agency.

6. To facilitate the accomplishment of these objectives, your committee recommends that a committee of not more than seven physicians representative of the practicing profession, under the chairmanship of Dr. Irvin Abell, President of the American Medical Association, be appointed by the Speaker to confer and consult with the proper federal representatives relative to the proposed National Health Program.

When Congress meets again, a bill embodying the proposals of the National Health Conference will undoubtedly be introduced and it will have the full support of the Roosevelt ad-

ministration. Be you a Democrat, Republican, Socialist or whatnot, as a Doctor of Medicine, will you permit the practice of medicine to be ravaged by a group of lustful politicians?

## IMPORTANCE OF CONSTITUTION AND BY-LAWS

The officers and the Executive Committee of the Florida Medical Association have been stressing during the last few months the need for each county medical society to adopt a constitution and by-laws.

This need is further brought home by the recommendations of the special meeting of the House of Delegates of the American Medical Association in Chicago last month. If these recommendations are followed, as they probably will be in a large part, it is the county society which is going to have control of the medical service in each county or district. In order that this control may be exercised by a legally constituted organization, it is essential that such an organization be officially formed, which means the adoption of a proper constitution and by-laws, immediately.

There is another important reason why this should be done. Without a constitution and by-laws, it is impossible for any county society to lay down rules and regulations for the control of its members, and such control is of prime importance.

It is also desirable that the constitution and by-laws of the county unit should conform to that of the state association.

If your county society has not yet adopted a constitution and by-laws, please see that this is done at once. The State Association will be glad to supply a sample form if you will have your County Secretary write to your State Association office, Box 1018, Jacksonville.

## TO AMERICA'S SCHOOLS—YOUR HEALTH!

To America's Schools, the American Medical Association and the National Broadcasting Company present the fourth series of dramatized radio stories on health and hygiene, broadcast for the special purpose of helping the schools to teach health.

These weekly programs are heard each



Wednesday at 2 p. m., *e. s. t.*, over stations affiliated with the Blue network.

The next month's schedule is as follows:

Oct. 19—"What is Health?" Introductory; explanatory.

Oct. 26—"Growing Strong." Favorable and unfavorable factors in growth and the maintenance of normal weight.

Nov. 2—"Seeing and Hearing Well." Hearing and vision; how to conserve these; how to recognize deviations; how to prevent loss.

Nov. 9—"Healthier Boys and Girls." So-called physical defects; their recognition; what can be done about them.

Nov. 16—"Healthful Play." Health values and hazards in sports and recreation, including football.

## REPORT OF FLORIDA DELEGATES TO AMERICAN MEDICAL ASSO- CIATION HOUSE OF DELEGATES

HERBERT L. BRYANS, M. D., Pensacola

MEREDITH MALLORY, M. D., Orlando

*To the Members of the Executive Committee,  
in Session at Ponte Vedra, Sept. 14, 1938:*

A few more than 6,000 physicians registered at the San Francisco Session, making it the largest meeting ever held on the Pacific Coast. California alone registered 3,143 and Illinois was second in attendance with 236. Rhode Island was low with only 3 while Florida registered 25.

In the scientific sessions the attendance was frequently beyond the capacity of even the large halls which had been assigned them. Many of the topics which have been in the forefront of medical consideration during the past year were exhaustively considered, including particularly blood dyscrasias, industrial diseases, and new methods in the treatment of psychiatric conditions.

The Canadian Medical Association had an official delegate present as well as the New Zealand branch of the British Medical Association, both of whom addressed the House of Delegates.

The retiring President, Dr. J. H. J. Upham of Columbus, Ohio, made a most forcible address. In part he said: "There are at the latest listing 100 national special societies holding yearly meetings. In addition there are numerous district meetings of similar character to meet the demands of sectional areas. These are purely scientific assemblies and the opinions and expressions of the members attending have a weight and authority that are duly acknowledged if confined within

the bounds of medical science. When, however, such societies have taken action on matters of medical policy, or officers of those organizations seize the opportunity to attract public notice by expressing personal opinions outside the real scope of the society, they collectively or individually arrogate to themselves an authority and importance that cannot be conceded by the rest of the medical profession." (*Page 33, J. A. M. A., July 2*).

The new President, Dr. Irvin Abell of Louisville, brought out several points in his address of paramount concern to organized medicine. "In any consideration of the indigent and the low income groups, social and economic factors play parts of equal importance with medical care. It is essential that the reciprocal relations of each be given careful consideration, to the end that medical and professional standards do not suffer as a result of projected experiments in legislative planning for socialization in various fields. The medical profession from prolonged and intimate observation is fully cognizant of the social and economic needs that lie so heavily on the indigent and low income groups. While willing to do its share in their rehabilitation, the medical profession does not feel it within its power or province to initiate or sponsor measures looking toward social and economic reformation; at the same time it resists efforts and proposals that would include and regiment its services under lay control to the accomplishment of those ends.

"There is no definite means of computing in monetary valuation the services voluntarily rendered to the indigent and low income groups by the doctors during the past eight years. From such data as are available a fair estimate based on a minimum fee schedule would place the valuation in the neighborhood of a million dollars a day, a contribution not equaled or exceeded by any agency except the Federal Government."

Doctor Abell brought out one other important fact that we think should be emphasized. He said: "It is difficult for us to understand the attitude of the socially minded statesman who would supply this group with medical care at Government expense with a lowering of the efficiency and perchance integrity, of a part of the medical profession and without providing for the beneficiaries a

standard of living that would maintain their own respect as free American citizens." (*Page 34, J. A. M. A., July 2*).

The California delegates introduced a resolution requiring of foreign graduates in medicine full citizenship in the United States before being licensed. The Reference Committee on Medical Education recommended its adoption.

The American Red Cross presented to the Board of Trustees for approval its Medical Policies in Disaster. It was referred to the Reference Committee on Reports of Board of Trustees who recommended that in general it be approved and emphasized that the primary responsibility for the care of the sick and injured in disaster rests with the local physicians and dentists; that the function of the Red Cross should be that of cooperation with local physicians and dentists by assisting in organizing and directing medical relief work and by providing the needed facilities that are lacking for the emergency. (*Page 35, J. A. M. A., July 2*).

The Reference Committee on Miscellaneous Business approved a resolution condemning the sale of sulfanilamide over the counter and its use by the public except when prescribed by a physician and taken under his observation.

The Judicial Council strongly recommended that all state associations and county societies review their present constitutions and by-laws with the object in view of such revision as may be necessary to meet present-day needs of medical practice and medical organizations. This Committee also reported some of our members are giving lectures in osteopathic schools and to optometrists. Some members are associated by a common waiting room in offices with them. Some members are by mutual agreement professional associates, principally in the field of surgery. There are some instances of partnership in practice. The Council stated that all of these voluntarily associated activities are unethical. It further stated that teaching in cultist schools and addressing cultist societies is even more reprehensible.

Several resolutions were offered from various sections of the country concerning the relation of radiologists, pathologists and anethetists to various hospital insurance plans.

In substance, the Council recommended that it jointly with the Bureau of Medical Economics be authorized to undertake these studies and confer with other interested agencies in order that it may be in a position to establish ethical standards for the practice of medicine by physicians holding positions in hospitals and to prevent the exploitation of either the public or the profession. If during this study it is revealed that hospitals registered and approved by the Council are exploiting the public or the profession, such approval may be revoked.

The prepared address of Miss Josephine Roche, Chairman of the Interdepartmental Committee to Coordinate Health and Welfare activities of the Federal Government was read by Dr. W. F. Draper, U. S. Public Health Service. It will be found in detail on page 52 of the July 2 issue of the A. M. A. Journal. The address was referred to the Reference Committee on Executive Session and in part they stated: "Possibly the most interesting data quoted are those which would indicate a much higher rate of sickness in the sub-economic groups. This raises the question whether the economics factor involved is not of greater importance than is the lack of medical care in the cause of illness. They further stated that they noted with satisfaction that a group of physicians has been invited to take part in the discussion of the National Health Conference the latter part of July and that it includes officers and leaders of the A. M. A."

The Medical Association of New Jersey introduced a resolution criticizing some of the writings of the Editor of the Journal of the A. M. A. (*Page 51, J. A. M. A., July 2*). The resolution was considered by the House of Delegates sitting as a Committee of the Whole and the resolution was rejected. (*Page 52, J. A. M. A., July 2*).

The Michigan State Medical Association presented a resolution proposing amendments to the By-Laws creating a Committee on Public Relations and the California State Medical Association introduced a cognate resolution requesting the Board of Trustees to employ professional public relations counsel. (*Pages 39 and 41, J. A. M. A., July 2*). These two resolutions were referred to a joint meeting of the Reference Committee on

Amendments to the Constitution and By-Laws and Committee on Legislation and Public Relations who reported in part as follows: "The foregoing considerations have led your Committee to return the proposed amendments and resolutions without its approval. However, the Committee feels impelled by reason of the sentiment revealed by the presentation of these proposed amendments and resolutions and the support of them from so many diverse quarters as well as by common knowledge of the frequent unsatisfactory attitude of the press, to ask the House of Delegates to impress on the Board of Trustees its feeling that careful consideration should be given to the operation of our agencies of public information, so that, on the one hand, the necessary *fortiter in re* may be preserved and on the other, that certain deficiencies of *suaviter in modo* may be corrected." (Page 60, *J. A. M. A.*, July 2).

In the report of the advisory Committee on Supply of Medical Care, they emphasized the importance of a medical survey made by the component county and state associations. The blank forms have already been sent out to the secretaries of the state associations who are supposed to distribute them to county societies. In the closing paragraph of their report, they stated: "This is your survey, not that of any bureau, committee or officer of the Association. It is squarely up to you and your constituents to carry it through successfully. It is no exaggeration to state that this survey may have a profound influence on the future course of American medicine." Your Delegates believe this to be of great importance and would urge the officers, Executive and Economics Committees of the State Association and County Societies to read this report in detail on page 54 in the July 2 issue of the *Journal of the A. M. A.* and to cooperate in every possible way to complete and expedite this survey.

The Section on Ophthalmology introduced a resolution on visual standards for operating motor vehicles which was adopted. (Page 58, *J. A. M. A.*, July 2).

Dr. Irvin Abell of Louisville, Kentucky, was installed as President. Dr. Rock Sleyster of Wauwatosa, Wisconsin, who served as Trustee of the A. M. A. from 1926 to June

1937 was unanimously elected President-elect. Dr. N. B. Van Etten of New York voluntarily retired as Speaker of the House of Delegates and the House expressed its appreciation of the consideration, inspiration and thought given it during his term as Speaker. Dr. H. H. Shoulders of Nashville, Tennessee (the Vice-Speaker, was unanimously elected Speaker of the House of Delegates. Dr. Roy W. Fouts of Omaha was elected Vice-Speaker.

The first Distinguished Service Medal was awarded to the well-known and loved Dr. Rudolph Matas of New Orleans.

St. Louis was selected as the 1939 meeting place.

Each of your Delegates served on Reference Committees; Meredith Mallory on Executive Session and Herbert Bryans on Amendments to Constitution and By-Laws.

Respectfully submitted,

HERBERT L. BRYANS,  
MEREDITH MALLORY.

## THE TYRANNY OF ABBREVIATIONS

When abbreviations are used in medical papers, in the recording of case histories or physical examinations or in operative or pathologic reports, the meaning should be entirely clear to all who may have occasion to read them. This is not, of course, the case. Abbreviations of medical terms are used obviously to save the time of the writer; too often, however, the time thus saved is wasted many times over by the person who is trying to decipher the meaning originally intended. When placed within a context, many of the abbreviations commonly employed in medicine are reasonably clear to those intimately familiar with the particular field; but when removed from such environment they become even more abstruse. Few readers for example can probably identify with ease such fairly commonly employed abbreviations as M. T. R., PeB., P. P. D., M. E. D., s. e. d., M. K. R., or K. P. Even when the abbreviations are placed in the proper setting many medical men would have difficulty in translating PeB into "near point of convergence," M. T. R. into "Meinicke flocculation reaction" or M. E. D. into minimal erythema dose."

From *J. A. M. A.* 111: 1103 (Sept. 17) 1938.



## MEDICAL DISTRICT MEETING—C

Ponte Vedra, September 15

The second annual meeting of the Northeast Medical District was held at Ponte Vedra on Thursday, at 3 p. m., with the Old Club as headquarters for the assembly and the Ponte Vedra Inn Cocktail Lounge for the buffet supper. The meeting was well attended and there were guests from many other districts. The total registration was 85. Of this number, 71 were Association members (from this district, 59); and 14 were visitors. At the close of the scientific session, Doctor Green urged those present who had not registered to do so immediately. There were so many entrances to the assembly room, quite a number of doctors were present who did not go to the registration desk. Also, a number of doctors arrived late and were present at the buffet supper but did not register. The total registration, therefore, as shown below, does not include some who failed to register and others who came later for the buffet supper.

The layout at the Ponte Vedra Inn was open to all members and their guests, as were the bathhouse on the beach, the golf course and many other attractions. A number of guests from other districts were present, including councilors from half the councilor districts. Dr. R. H. McGinnis of Jacksonville, who was president of the State Association in 1915, was present. Since Doctor McGinnis has not attended medical meetings regularly, he was greeted warmly on this occasion by his many friends. Of the six past presidents in this medical district, all were present but one, who was out of town. This meeting was a decided success, not only from the standpoint of the program, but also because of the opportunity it afforded the doctors in the district to get together and discuss their problems. Officers of the State Association, councilors from the various districts, chairmen of standing committees and other official representatives had an opportunity to discuss the activities of organized medicine.

At 3:45 p. m. the president of the medical district and councilor of district number 5, Dr. W. McL. Shaw, called the meeting to order. Dr. J. Lunsford Boone, president of the Duval County Medical Society, gave the address of welcome. Dr. W. Henry Spiers,

president of the State Association, then was called upon and reviewed plans for activities in the medical program for Florida. Since Dr. Shaler Richardson, secretary-treasurer of the Association and editor of the Journal, was attending a meeting in Chicago, Stewart Thompson was called upon as a substitute. Dr. Harrison A. Walker, chairman of the Council, was then recognized and gave a very comprehensive outline of the many activities undertaken by the Council. Dr. Leigh F. Robinson, president-elect of the State Association, was recognized by the chair and made a brief address. Dr. Gilbert S. Osincup, chairman of the Executive Committee, was attending the Chicago meeting and, at his request, Dr. Louie Limbaugh, a member of the Executive Committee, substituted for him. The following chairmen of standing committees of the Association were recognized and made brief reports: Dr. T. Z. Cason, Medical Postgraduate Course Committee; Dr. Ferdinand Richards, Maternal Welfare Committee; Dr. Luther W. Holloway, Child Health Committee; and Dr. Gordon H. Ira, Advisory to Woman's Auxiliary. Doctor Richards requested the recognition of Dr. F. V. Chappell of the State Board of Health, since he and his Bureau are cooperating so nicely with the program of the Maternal Welfare Committee. The following past presidents of the State Association were recognized: Drs. R. H. McGinnis, H. Marshall Taylor, Frederick J. Waas, Gerry R. Holden and Edward Jelks. Dr. Shaw then called on Dr. W. A. McPhaul, State Health Officer, who made a brief address, stating that he and all his associates were cooperating wholeheartedly, not only with the various departments of the Florida Medical Association, but also with the officers and committees of the various county medical societies.

The next order of business was the selection of a meeting place for 1939. Dr. Z. Brantley, president of the Putnam County Medical Society, extended an invitation to meet in Palatka. Dr. George M. Green extended an invitation to meet at Daytona Beach. Owing to the fact that the Medical Short Course meeting was held at Daytona Beach this year and that the annual meeting of the State Association will be held there

next spring, Doctor Green withdrew his motion and urged the acceptance of the Putnam County Medical Society's invitation for Palatka as the place of meeting in 1939 for the Northeast Medical District. A motion was made and a unanimous vote cast for accepting Doctor Brantley's invitation.

The scientific session then convened and the gavel was turned over to Dr. George M. Green, president-elect of the Medical District and councilor for district number 6. The first essayist was Dr. C. E. Tribble of DeLand, who read a paper on "Dystocia Due to Sacral Teratoma." The second essayist was Dr. Allen P. Gurganious of Palatka, who read a paper on "Common Sense Medicine." The last paper presented was by Dr. E. B. Wood of Daytona Beach on "Coronary Occlusion." These scientific papers were well presented and drew close attention from all present. During the discussions of the papers, it was very evident that the listeners enjoyed and appreciated the essayists' efforts. Dr. V. A. Lockwood of St. Augustine was unable to read his paper, as he was unexpectedly called to New York.

After the scientific session a meeting of the Council was called by the chairman, Dr. H. A. Walker. There were six councilors present at this called meeting, which represents half the councilors in the state. Doctor Walker expressed his appreciation of such a splendid attendance of councilors at this meeting. Several items of routine business concerning the activities of the Council were passed upon.

A very delicious buffet luncheon was served in the cocktail lounge of the Ponte Vedra Inn. The food was excellent and everyone present had a delightful time. There was no set program but some of the musically inclined doctors were arranged in groups and the harmony of male voices was heard throughout the building. We understand the enjoyable entertainment did not cease at the close of the supper festivities, although that was the end of the official program. Unofficially it was learned that there was a dance at the bath club and that the doctors and their guests were extended an invitation to attend. This was a special courtesy, as this bath club is restricted to members only.

## REGISTRATION

Shaw, W. McL., *President*..... Jacksonville  
Green, George M., *President-elect*..... Daytona Beach  
Thompson, Stewart, *Managing Director*... Jacksonville

## Association Members

Ashton, W. L..... Umatilla  
Bell, F. Emory..... Palatka  
Black, John B..... Jacksonville  
Boone, J. L..... Jacksonville  
Borland, James L..... Jacksonville  
Brantley, Z..... Grandin  
Brooks, W. H..... Jacksonville  
Cason, T. Z..... Jacksonville  
Chappell, F. V..... Jacksonville  
Croft, Theodore G..... Jacksonville  
Day, H. A..... Orlando  
Driskell, S. E..... Jacksonville  
Dyrenforth, L. Y..... Jacksonville  
Erwin, Stanley..... Jacksonville  
Floyd, George M..... Hawthorne  
Fort, F. L..... Jacksonville  
Gonzalez, L. C..... Jacksonville  
Goodale, B. H..... Jacksonville  
Gurganious, Allen P..... Palatka  
Hanson, Karl..... Jacksonville  
Harkness, R. B..... Lake City  
Harris, W. G..... Jacksonville  
Holden, Gerry R..... Jacksonville  
Holloway, L. W..... Jacksonville  
Ira, Gordon H..... Jacksonville  
Jelks, Edward..... Jacksonville  
Jewett, E. L..... Orlando  
Kenaston, T. C..... Cocoa  
King, Raymond..... Jacksonville  
Kirby-Smith, J. L..... Jacksonville  
Limbaugh, Louie..... Jacksonville  
Lyerly, J. G..... Jacksonville  
McCreary, A. B..... Jacksonville  
McCullagh, W. H..... Jacksonville  
McGinnis, R. H..... Jacksonville  
McIver, Robert B..... Jacksonville  
McPhaul, W. A..... Jacksonville  
Mabry, Charles B..... Jacksonville  
Manning, W. S..... Jacksonville  
Merritt, J. W..... Jacksonville  
Miller, R. L..... Daytona Beach  
Oetjen, Frederick..... Jacksonville  
Page, W. C..... Cocoa  
Payton, Frazier J..... Miami Beach  
Peyton, Harry A..... Jacksonville  
Randolph, J. H..... Jacksonville  
Richards, Ferdinand..... Jacksonville  
Richardson, George W..... Jacksonville  
Robinson, Leigh F..... Ft. Lauderdale  
Rollins, C. D..... Jacksonville  
Royce, C. E..... Jacksonville  
Sellers, E. T..... Jacksonville  
Slaughter, Frank G..... Jacksonville  
Spencer, J. J..... St. Augustine  
Spiers, W. Henry..... Orlando  
Stinson, W. M..... Jacksonville  
Strange, J. L..... McIntosh  
Swift, E. C..... Jacksonville  
Taylor, H. Marshall..... Jacksonville  
Tribble, C. E..... DeLand  
Tyler, L. V..... Jacksonville  
Vcal, E. W..... Jacksonville  
von Meysenbug, Ludo..... Daytona Beach  
Waas, F. J..... Jacksonville  
Walker, H. A..... Miami Beach  
Wells, J. Ralston..... Daytona Beach  
White, Herbert E..... St. Augustine  
Wilkinson, A. H..... Jacksonville  
Wood, Evans B..... Daytona Beach



*Visitors*

Adams, Mark E.	Jacksonville
Anderson, E. V.	Jacksonville
Arnow, Matthew	Jacksonville
Blackman, R. S.	Jacksonville
Brown, E. H.	Jacksonville
Cox, R. H.	Jacksonville
Hill, John H.	Jacksonville
Horn, P. W.	Jacksonville
Morse, G. W.	Jacksonville
Patterson, J. N.	Jacksonville
Price, George W., Jr.	Jacksonville
Provinsky, L. B.	Jacksonville
Wachtel, L. M., Jr.	Jacksonville

## MEDICAL DISTRICT MEETING—D

BRADENTON, SEPTEMBER 29

The second annual meeting of the Southwest Medical District was held at Bradenton, Thursday afternoon at 3 o'clock, with headquarters at the Dixie Grande Hotel. There was a total registration of 78. Of this number, 58 were Association members (from this district, 52); 4 were visitors; and 16 were ladies.

Notwithstanding the fact that Bradenton is in the extreme south of the medical population of the district, the attendance this year was fifty per cent larger than at last year's meeting. Many doctors were in attendance who have seldom been seen at the State Association's annual conventions. The Local Committee on Arrangements, composed of Drs. Charles W. Larrabee, Lowrie W. Blake and W. D. Sugg, had made careful preparations for the meeting and looked after the comfort and pleasure of the members and guests throughout the afternoon and evening.

At 3:30 p.m. the meeting was called to order by Dr. John W. Alsobrook, president of the district. Owing to sickness, Dr. John F. Mason, president of the Manatee County Medical Society, was unable to welcome the members and guests and Dr. T. M. McDuffee gave the address of welcome. The Chief of Police, armed and in uniform, appeared at the door and was called to the front of the room. The police officer, in addressing the group, extended the services of his personnel to the doctors and their guests during the meeting, and requested anyone getting into trouble to call him personally.

Dr. W. Henry Spiers, president of the State Association, was called upon by the presiding officer and gave a very interesting outline of the plans for Association affairs during the year. President Spiers also explained in de-

tail, proposed legislation. Dr. Harrison A. Walker, chairman of the Council, was then recognized and gave an instructive talk on the activities of the twelve councilors. One point emphasized by Doctor Walker was that, for the past two years, in addition to the six annual district meetings supervised by the Council during each year, they have been also quite active in many other phases of the Association's activities. Dr. Gilbert S. Osincup, chairman of the State Association's Executive Committee, made a brief address, emphasizing the importance of county societies adopting a uniform fee schedule and asking those present who had not already received a mimeographed copy of the fee schedule which has been proposed, to secure one from the secretary of the county society. Doctor Osincup also explained very forcefully the importance of, and urged every county society in Florida to have an up-to-date constitution and by-laws. A suggested outline of county society constitution and by-laws, prepared by the A. M. A. in printed form, may be secured by the secretary of any county medical society, by writing to the Association's office, P. O. Box 1018, Jacksonville.

Dr. Meredith Mallory, one of the Association's representatives to the American Medical Association's House of Delegates, was present. Doctor Mallory had attended the special meeting of the House of Delegates in Chicago in September, and presented a very interesting report of that meeting. The doctors present were quite pleased to have had this opportunity of hearing Doctor Mallory's report concerning the questions of vital interest to the profession that were taken up by the National Association's body. The importance of these medical district meetings was emphasized by this unusual opportunity of hearing personally, at such an early date, from the Chicago meeting.

Dr. W. A. McPhaul, State Health Officer, was then recognized and made a short talk. Dr. Louie Limbaugh of Jacksonville, a member of the Executive Committee, was also present and recognized by the presiding officer. Three of the six past presidents in this medical district were present and were called upon by the Chair: Dr. H. Mason Smith, 1926, Tampa; Dr. John A. Simmons, 1927, Arcadia; and Dr. O. O. Feaster, 1936, St.



Petersburg. All of the past presidents emphasized in their talks the importance of these medical district meetings.

The next order of business was the selection of a meeting place for 1939. On behalf of the Polk County Medical Society, Dr. Herman Watson extended an invitation to meet in Lakeland next year. By unanimous vote, the invitation was accepted for Lakeland.

After a short recess, the scientific session was called to order by Dr. Herman Watson, president-elect of the medical district, who presided. The first essayist was Dr. W. C. McConnell of St. Petersburg, who read a paper on "The Insured Neurotic." The second paper was by Dr. Jere W. Annis and John W. Vaughn of Lakeland, on "Myocardial Infarction: Electrocardiographic Changes and Necropsy Findings." The paper was read by Doctor Vaughn and illustrated with slides by Doctor Annis. The third paper was by Dr. L. W. Martin of Sebring on "Meckel's Diverticulum." Dr. N. L. Marcus of Tampa presented the fourth paper which was entitled "Case of Agranulocytosis With Review of Literature" and illustrated with lantern slides. All the papers were well presented and the interesting discussions that followed, in addition to the close attention paid by the listeners, were a tribute to the efforts of the essayists.

At 7 p. m. a delectable dinner was served in the dining room of the Dixie Grande Hotel, Dr. Charles W. Larrabee acting as toastmaster. A very delightful time was enjoyed during the dinner hour, as the toastmaster called for extemporaneous speeches from officers of the Association and various other doctors. By special request, Dr. Jack Halton of Sarasota rendered a vocal solo. Following the dinner, a paper was read on medical economics by Dr. Nathaniel L. Spengler of Tampa. The Local Committee on Arrangements provided a very fine orchestra during the dinner and at the close of this part of the program all members and guests were invited to the patio for dancing.

#### REGISTRATION

Alsobrook, J. W. *President*.....Plant City  
Watson Herman, *President-Elect*.....Lakeland  
Thompson, Stewart, *Managing Director*.....Jacksonville

#### Association Members

Andrews, C. A.....Tampa  
Annis, J. W.....Lakeland  
Bevis, H. P.....Arcadia

Blake, L. W.....Bradenton  
Blake, W. C.....Tampa  
Boling, John R.....Tampa  
Burgner, Blanche A.....Sarasota  
Carter, E. F.....Tampa  
Cline, R. L.....Lakeland  
Cook, George L.....Tampa  
Cribbins, O. H.....Sarasota  
Farrington, Charles L.....Tampa  
Feaster, O. O.....St. Petersburg  
Gates, H.....Bradenton  
Gill, E. B.....Arcadia  
Halton, Jack.....Sarasota  
Harris, J. E.....Sarasota  
Harrison, M. M.....Bradenton  
Hollingsworth, S. G.....Bradenton  
Kirkpatrick, C. H.....Arcadia  
Knauf, A. R.....Tampa  
Lancaster, L. L.....Lake Wales  
Larrabee, C. W.....Bradenton  
Limbaugh, Louie.....Jacksonville  
Lowry, B. W.....Tampa  
McConnell, W. C.....St. Petersburg  
McDuffee, T. M.....Manatee  
McPhaul, W. A.....Jacksonville  
Maguire, T. C.....Plant City  
Mallory, Meredith.....Orlando  
Marcus, Nathan L.....Tampa  
Martin, L. W.....Sebring  
Metzger, Frank C.....Tampa  
Mills, H. R.....Tampa  
Morton, A. O.....Sarasota  
Murphey, David R., Jr.....Tampa  
Murphy, C. H.....Bartow  
Myers, N. P.....Bradenton  
Osincup, Gilbert S.....Orlando  
Patterson, J. C.....Sarasota  
Simmons, John A.....Arcadia  
Smith, H. Mason.....Tampa  
Spengler, N. L.....Tampa  
Spiers, W. Henry.....Orlando  
Sugg, W. D.....Bradenton  
Taylor, Joseph W.....Tampa  
Tomlinson, J. P., Jr.....Lake Wales  
Vaughn, J. W.....Lakeland  
Walker, Harrison A.....Miami Beach  
Wentzel, W. E.....Bradenton  
Whitaker, H. E.....Tampa  
White, Millard B.....Sarasota  
Wilson, C. B.....Sarasota  
Wilson, John F.....Lakeland  
Wood, A. J.....St. Petersburg  
Woods, E. B.....Tampa

#### Visitors

Cuthbert, Guy E.....Tampa  
English, Dr. A. Q.....Palmetto  
Johnston, Dr. W. J.....Sarasota

#### Woman's Auxiliary—Members and Guests

Blake, Mrs. L. W.....Bradenton  
Cain, Velma.....Sarasota  
Farrington, Mrs. Charles L.....Tampa  
Gates, Mrs. H.....Bradenton  
Halton, Mrs. Jack.....Sarasota  
Harrison, Mrs. M. M.....Palmetto  
Lancaster, Mrs. Blake.....Manatee  
Larrabee, Mrs. C. W.....Bradenton  
McConnell, Mrs. Ethel L.....St. Petersburg  
Murphey, Mrs. D. R., Jr.....Tampa  
Murphy, Mrs. C. H.....Bartow  
Patterson, Mrs. J. C.....Sarasota  
Simmons, Mrs. John A.....Arcadia  
Stewart, Mrs. Daniel A.....Sarasota  
Walker, Mrs. Harrison A.....Miami Beach  
Willis, Mrs. Lynn.....Bradenton

SCIENTIFIC PROGRAM  
FLORIDA EAST COAST MEDICAL  
ASSOCIATION

ROCKLEDGE

October 28 and 29, 1938

Friday, October 28, 2 p. m.

1. "Unusual Cases of Gonorrhea," John E. Hall, Miami.  
Discussion: E. T. Sellers, Jacksonville;  
H. D. Clark, Fort Pierce.
2. "The Value and Significance of the Tuberculin Test," A. J. Logie, Jacksonville.  
Discussion: L. S. Laffitte, Jacksonville;  
Robert M. Harris, Miami.
3. "Acute Perforating Duodenal Ulcers," Frederick J. Waas, Jacksonville.  
Discussion: Harrison A. Walker, Miami Beach;  
I. M. Hay, Melbourne.
4. "Oligurias with Blood Transfusions," Harold H. Fox, Miami.  
Discussion: C. C. Mendoza, Jacksonville;  
T. E. Buckman, Jacksonville.
5. "Experiences with Fractures of the Head of the Radius," Frank G. Slaughter, Jacksonville.  
Discussion: John F. Lovejoy, Jacksonville;  
A. M. Sample, Fort Pierce.

Saturday, October 29, 9 a. m.

6. "Differential Diagnosis of Jaundice," Fred Mathers, Orlando.  
Discussion: T. C. Kenaston, Cocoa;  
Kenneth A. Morris, Jacksonville.
7. "Mesenteric Cysts," J. W. Snyder, Miami.  
Discussion: Leigh F. Robinson, Fort Lauderdale;  
H. D. Van Schaick, Jacksonville.
8. "The Treatment of Coronary Occlusion," Evans B. Wood, Daytona Beach.  
Discussion: S. Marion Salley, Miami;  
Stanley Erwin, Jacksonville.
9. "The Psychological Aspect of the Diagnosis of Intestinal Obstruction," Joseph S. Stewart, Miami.  
Discussion: Herbert E. White, St. Augustine;  
J. R. Chappell, Orlando.
10. "The Surgical Kidney in Obstetrics," Robert B. McIver, Jacksonville.  
Discussion: T. S. Field, Jacksonville;  
E. T. Sellers, Jacksonville;  
S. R. Norris, Jacksonville;  
Ferdinand Richards, Jacksonville.

STATE NEWS ITEMS

Dr. Herbert L. Bryans and Dr. Meredith Mallory, the Florida delegates to the A. M. A. House of Delegates; Dr. Shaler Richardson, Secretary of the Association; and Dr. Gilbert S. Osincup, Chairman of the Association's Executive Committee, attended the Special Session of the A. M. A. House of Delegates held in Chicago, September 16-17, 1938.

\* \* \*

Dr. William C. Blake of Tampa presented a paper on "Should Non-Tuberculous Lung

Diseases be Treated in the Tuberculosis Sanatorium" at the Southern Tuberculosis Conference, held in Louisville, Kentucky, September 19-20.

\* \* \*

The Florida Society of Dermatology and Syphilology will hold its ninth annual meeting in Jacksonville, Sunday, November 13 at 9 a. m., at the Duval County Hospital. Dr. J. L. Kirby-Smith, Jacksonville, is chairman for the meeting.

\* \* \*

Dr. Russell W. Ramsey has purchased the office and equipment of the late Dr. B. A. Burks, in Winter Park. The office is undergoing extensive alterations and will be both attractive and well equipped, when completed.

\* \* \*

Dr. R. P. Stritzinger of Pensacola announces the removal of his offices to larger quarters in the Blount Building. He now occupies rooms 410-411.

\* \* \*

The Southern Medical Association's annual meeting will be held in Oklahoma City, November 15-18. On the back cover of the September Journal, railroad fares and train schedules, submitted by the Atlantic Coast Line Railroad Company, will be found. The A. C. L. will operate through pullman cars from Jacksonville. Please refer to the back cover of your September Journal for more detailed information concerning the meeting in Oklahoma City.

\* \* \*

Dr. J. Maxey Dell, Sr., of Gainesville, was recently named mayor-commissioner of Gainesville. Doctor Dell is superintendent of the Florida Farm Colony.

\* \* \*

Dr. Juriah H. Pierpont of Pensacola was presented with a scroll signed by the members of the Escambia County Medical Society, on August 2, as recognition of his completion of fifty years' practice in the county.

\* \* \*

Dr. J. C. Pate of Tampa addressed the International College of Surgeons at Philadelphia, October 14. The subject of his paper was "The Status of Gall Bladder Surgery."

Dr. G. E. Osgood, of St. Petersburg, an honorary member of the Pinellas County Medical Society and the Florida Medical Association, died recently.

\* \* \*

Dr. Thomas B. Echard of St. Petersburg, an honorary member of the Pinellas County Medical Society and the state association, died September 24, 1938.

\* \* \*

Dr. Butler H. Sanchez of Plant City, a member of the Hillsborough County Medical Society, died September 21, 1938, following a six weeks' illness.

\* \* \*

Dr. T. Z. Cason of Jacksonville was principal speaker at the local Lions Club luncheon on September 23. The talk brought out the difference in service under the present form of private practice and under State Medicine.

\* \* \*

The following members of the Florida Medical Association attended the meeting of the American Roentgen-Ray Society, held in Atlantic City, September 20-23: Drs. J. C. Dickinson, Tampa; F. K. Herpel, West Palm Beach; Thomas H. Lipscomb, Jacksonville; J. H. Lucinian, Miami; Frazier J. Payton, Miami Beach, and W. McL. Shaw, of Jacksonville.

\* \* \*

Dr. and Mrs. George A. Dame, their two sons, George and John, and Mrs. Dame's mother, of Inverness, returned recently from an extensive vacation trip through the western states. Doctor Dame will serve his second term in 1939, as senator in the Florida legislature.

\* \* \*

The staff of the new medical center, located at 24 West Chase Street, Pensacola, is composed of Drs. C. C. Webb, A. E. Mock, W. P. Hixon, C. J. Heinberg, A. W. White and Lee Sharp.

\* \* \*

Dr. E. B. Gill announces his removal from Sebring to Arcadia where he has opened an office in the DeSoto National Bank Building.

Dr. Jess V. Cohn of Hollywood returned recently from a combined pleasure and study trip involving the east and middle west, including Johns Hopkins Hospital and the Cincinnati General Hospital.

\* \* \*

Dr. Elias Freidus, a member of the Dade County Medical Society, expects to return to Miami Beach this fall. Doctor and Mrs. Friedus intend to make Miami Beach their permanent home.

\* \* \*

Dr. Clarence D. Rollins of Jacksonville returned last month from a week's vacation spent with relatives in South Carolina.

\* \* \*

Dr. and Mrs. J. F. Lovejoy of Jacksonville announce the birth of a son, John Fletcher, Jr., on September 15 in St. Luke's Hospital.

\* \* \*

Dr. and Mrs. M. J. Henderson of Live Oak announce the birth of a daughter, Mary Love, on September 8 in Riverside Hospital, Jacksonville.

\* \* \*

Dr. B. H. Lawson of Winter Garden has annexed another title. His first grandchild, Elizabeth Anne Cowart, arrived September 15, 1938, at St. Luke's Hospital, Jacksonville.

\* \* \*

Dr. and Mrs. Jack Halton of Sarasota have just returned from six weeks spent in the North, during which time Doctor Halton did rectal work in Cincinnati, St. Louis, and Louisville hospitals.

\* \* \*

Dr. Henry Hanson was decorated by the Ecuadorean government for services in Ecuador, fighting the bubonic plague. The official Order of Merit of the Ecuadorean government was conferred upon Doctor Hanson for work against the plague and for giving the country the benefits of his scientific knowledge.

\* \* \*

A doctor's bag and contents were found on the Ocala-Gainesville Road, September 29. Anyone learning of the owner, please notify M. M. Letts, General Delivery, Ocala, Fla.



Dr. S. Ward Fleming of West Palm Beach attended the Third International Goiter Conference which was held in Washington, D. C., September 12-14.

\* \* \*

Dr. Joseph W. Taylor of Tampa attended the National Amateur Golf Tournament at Pittsburgh, Pennsylvania, recently. Doctor Taylor's son, Joe, Jr., a student at Duke University, was one of the contestants from Florida.

## COMPONENT COUNTY SOCIETIES

### DADE COUNTY MEDICAL ASSOCIATION

The meeting of the Dade County Medical Association held on the evening of October 4 was devoted to the discussion of medical economics. Opening talks were made by Drs. C. P. Lamar, M. Jay Flipse, and George Lilly.

On September 13, 1938, by order of the Hon. Paul D. Barnes, Judge of the Circuit Court of the Eleventh Judicial Circuit of Florida, the Charter (Constitution) of the Association was created and its new By-laws approved. On September 20, 1938, by order of this same Judge and Court, the plea for dissolution of the old Charter was granted. The resolution passed by the Association, asking this dissolution together with transfer of all properties, memberships, etc., to the new corporation, was also approved. Henceforth the name of the organization shall be the Dade County Medical Association, Inc.

\* \* \*

### DE SOTO-HARDEE-HIGHLANDS-CHARLOTTE

#### GLADES COUNTY MEDICAL SOCIETY

On request of the DeSoto-Hardee-Highlands County Medical Society, the Executive Committee at its last meeting, approved changing the name of the Society to DeSoto-Hardee - Highlands-Charlotte-Glades County Medical Society. Several doctors in the two added counties have designated their intention of affiliating with the society and it was to give these doctors recognition that the name was changed.

\* \* \*

### DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular monthly meeting in the library of the State Board of Health, Jacksonville, on the



AS FLOWS "BLACK GOLD" FROM deep wells, so will flow the latest in scientific and practical medicine and surgery from deep wells of scientific knowledge, values greater than any kind of gold—Southern Medical Association meeting, Oklahoma City, November 15-18, 1938.

—o—

## THE WORTH OF MEDICAL MEET-

INGS to the physician is not the purpose of this announcement since the alert profession has come to recognize the value of keeping abreast through this channel. Rather, the purpose is to urge physicians to attend more medical meetings regularly.

Of particular interest to the profession in the South are the annual meetings of the Southern Medical Association where clinical sessions, nineteen sections and an expanse of scientific and technical exhibits constitute a four day education in the later developments of scientific medicine.

Surely, the meeting this year in Oklahoma City will be one well chosen for the specialist or general practitioner alike; the program will afford keen interest to both in the wide variety of meetings and exhibits, all being housed under one roof, the easily accessible Municipal Auditorium.

ALL MEMBERS OF STATE AND COUNTY medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$4.00 include the Southern Medical Journal—the equal of any, better than many.

## SOUTHERN MEDICAL ASSOCIATION

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evening of October 4. Dr. Gilbert S. Osincup of Orlando was guest speaker and gave a report of the Special Meeting of the A. M. A. House of Delegates which was held in Chicago, September 16 and 17.

The scientific program consisted of the following papers: "Some Considerations of Hyperthyroidism from a Medical Viewpoint" by Dr. Webster Merritt and "Complications in Thyroid Surgery" by Dr. Frank G. Slaughter. Following the meeting refreshments were served.

\* \* \*

#### MARION COUNTY MEDICAL SOCIETY

THE MARION COUNTY MEDICAL SOCIETY HAS PAID ITS ENTIRE ASSESSMENT OF 1938 DUES. THIS SOCIETY, WHICH DRAWS ITS MEMBERS FROM 8 CITIES, IS THIS YEAR HEADED BY DRS. CARNEY W. MIMMS, OCALA, PRESIDENT; EDWIN C. HANSON, BELLEVIEW, VICE-PRESIDENT; AND R. C. CUMMING, OCALA, SECRETARY - TREASURER. CONGRATULATIONS, MARION COUNTY MEDICAL SOCIETY!

\* \* \*

#### PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. Claude L. Carter entertained the Pasco-Hernando-Citrus County Medical Society at Inverness, September 8. Dinner was served at the Orange Hotel followed by a business and scientific meeting in the sun-parlor of the hotel.

Minutes of the last meeting were read and approved. Dr. David B. Manley of Zephyrhills was elected to membership. Blanks from the State Association were distributed with the request that each doctor make a weekly report of the type of patients handled. Each doctor present then presented an interesting case report.

Attending this meeting were: Drs. J. T. Bradshaw, Claude L. Carter, G. R. Creekmore, George A. Dame, H. L. Harrell, S. C. Harvard, W. Wardlaw Jones, David B. Manley and William Haywood Walters.



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Formerly sixteen years Superintendent  
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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**The Mechanism of Production of Digestive Symptoms Associated with Urologic Pathology**—WELCH, P. B.; COPLAN, MILTON M., and HOLMES, ROY J., Miami. *Am. J. Digest Dis. & Nutrition* 4:797-802 (Feb.), 1938.

Many reflex gastro-intestinal symptoms are associated with or produced by urologic pathology, and it has been assumed that these were due to changes in the muscular activity of the intestine and stomach, but the exact nature and location of these muscular changes has not been described. These symptoms as seen in forty-eight cases and in the order of relative frequency are: epigastric distress, diffuse abdominal pain, eructation and regurgitation, urinary symptoms, nausea and vomiting, pain in the right lower quadrant, backache, heartburn, pain in the flank, diarrhea, pain in the left lower quadrant, anorexia, hunger pains, pain in the left upper quadrant, pain in the thigh and hip, pain in the left shoulder, distention, tachycardia, dysphagia and rectal tenesmus. All these were relieved by urologic treatment, and before proper treatment had led to such diagnoses as peptic ulcer, gastric hypermotility, cardiospasm, pylorospasm, ileal regurgitation, irritable colon, colon stasis, proctitis, spasm of anal sphincter, diverticulosis, visceroptosis and cholelithiasis. Twelve of these forty-eight patients had submitted to various abdominal operations without relief of their symptoms.

To demonstrate the nature of these symptoms associated with urologic pathology, the authors used dogs and patients experimentally. Inflatable balloons were put into the stomach and duodenum of dogs and patients and attached to a duodenal tube, and into the colon of two patients who had had permanent colostomies. By attaching these tube systems to indicators, variations in pressure of these balloons in the stomach or intestines could be studied and traced chymographically. Such studies revealed that the muscular activity of the stomach and duodenum is increased when associated with urologic pathology, and that



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the normal "feeding reflex" of the stomach is definitely reversed. Trauma in the urologic tract is associated in the colon with at first an inhibition of the clonic peristalsis, which is then followed by marked but irregular increases in tone and clonic peristalsis. The side on which the urologic pathology exists is not the determining factor as to the location of the digestive disturbances.

A careful study of the complete paper is recommended.

**Medical and Surgical Treatment of Chronic Prostatitis**—ORR, LOUIS M., II. Orlando. *Am. J. Surg.* 39:602-606 (Mar.), 1938.

Satisfactory results may be obtained in the treatment of chronic prostatitis of fairly recent origin by the simple methods in general use both by the practitioner and the urologist. These consist of frequent prostatic massage associated with the passage of sounds and subsequent instillation of various silver preparations. Heat also has a wide field of usefulness in the form of Elliott treatments, hot sitz baths and rectal irrigations of hot water.

Other less frequently used methods, noted by the author, include intravenous medication (mercurochrome, neosarsphenamine); vasostomy (operation of Belafeld) with injection of argyrol or mercurochrome into the seminal vesicles; catheterization of the ejaculatory ducts and direct prostatic injection of aqueous mercurochrome.

In the more resistant types, comprising 5-10% of the total prostatic infections, a more radical type of procedure must be followed. The author, by using a fine wire loop in the resectoscope, removes usually two sections,  $\frac{5}{8}$  to  $\frac{7}{8}$  of an inch in length on either side of the verumontanum and one section in the urethral floor. The result of this procedure is to form new orifices for prostatic ducts that have been closed, thus producing improvement in prostatic drainage.

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**Bacillus Violaceous Infection In a Human Being**—BLACK, M. E., and SHAHAN, JOHN, Clearwater. *J.A.M.A.* 110:1270-1271 (Apr. 16), 1938.

*Bacillus violaceous* infection is practically unknown in human beings and heretofore considered non-infectious for humans. A detailed case report is furnished:

A six year old child gave history of having waded in stagnant rain water in low ground, which was followed in a few days by fever, changes in the skin and the usual gastro-intestinal symptoms of a toxic infection. The skin lesions on the left arm, the abdomen, and the right side of the trunk, accompanied by lymphadenitis of the adjacent nodes, were similar to those of anthrax, except that the dark eschar centers of the lesions were a mahogany brown, and surrounded by a pustular area which had a characteristic violaceous color. The organism which was recovered was morphologically and culturally like *bacillus violaceous*. It produced a rapidly fatal infection with similar skin lesions in a rabbit. The child was desperately ill for about two weeks, with rapid exhaustion, development of anemia, and loss of weight. Repeated blood transfusions seemed to be the only therapeutic agent of any value. All local treatments to the lesions seemed to be valueless. Slight fever persisted into the fifth week of the illness and the last of the skin lesions healed about ten weeks after the onset. A violet pigmentation has persisted in the healed lesions.

### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**THE VITAMINS AND THEIR CLINICAL APPLICATION.** By PROF. W. STEPP, DOCENT KUHNNAU, DR. H. SCHROEDER and H. A. H. BOUMAN, M.D., translator. This enlightening and intensively practical manual on vitamins has recently been translated by H. A. H. Bouman, M.D., of Minneapolis, Minnesota, and should be of interest to every physician who wants to understand the use of vitamins in his daily practice. It takes up each of the known vitamins separately, giving its history, chemistry, determination, occurrence, manifestations, absorption, clinical application, physiology, preparation and dosage. Included is a chart of the survey of vitamins known today and a chart showing contents of essential vitamins in various diets. Cloth. Pp. 173; price, \$4.50. The Wisconsin Cueno Press, Inc. This book is available from the Vitamin Products Company, Milwaukee, Wisconsin.

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## STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	W. Henry Spiers, Orlando.....	Shaler Richardson, Jacksonville....	Daytona Beach, 1939
Florida Medical Districts:			
A—Northwest .....	N. A. Baltzell, Marianna .....	Stewart Thompson, Jacksonville....	Marianna, 1939
B—North Central .....	R. B. Harkness, Lake City .....	" " " .....	Gainesville, Oct. 27, 1938
C—Northeast .....	W. McL. Shaw, Jacksonville .....	" " " .....	Palatka, 1939
D—Southwest .....	J. W. Alsobrook, Plant City .....	" " " .....	Lakeland, 1939
E—South Central .....	H. D. Clark, Ft. Pierce .....	" " " .....	Eustis, Nov. 10, 1938
F—Southeast .....	H. A. Walker, Miami Beach .....	" " " .....	Ft. Lauderdale, Oct. 13, 1938
Alabama Medical Association.....	Seale Harris, Montgomery .....	D. L. Cannon, Montgomery .....	Montgomery, Apr. 18-20, 1939
Georgia Medical Association.....	Grady N. Coker, Canton .....	E. D. Shanks, Atlanta .....	Atlanta, May 9-12, 1939
Florida—			
State Dental Association.....	R. D. Cummins, St. Petersburg .....	Lloyd Harlow, Bradenton .....	Jacksonville, Nov. 10-12, 1938
Soc. of Derm. and Syph. ....	C. A. Andrews, Tampa .....	Lauren Sompayrac, Jacksonville....	Jacksonville, Nov. 13, 1938
East Coast Medical Association.....	Walter C. Jones, Miami .....	T. C. Kenaston, Cocoa .....	Rockledge, Oct. 28, 29, 1938
State Hospital Association .....	Gertrude Overstreet, Gainesville.....	Mr. Fred Walker, Jacksonville....	Jacksonville, Apr. 13-15, 1939
Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville .....	Chairman .....	
Midland Medical Society .....	W. C. McConnell, St. Petersburg .....		Sebring, Oct. 27, 1938
State Nurses Association.....	Mrs. Inez Nelson, Orlando .....	Mrs. Phyllis Leonard, St. Augustine .....	Sarasota, Nov. 7-9, 1938
Pediatric Society .....	Gilbert S. Osincup, Orlando .....	Warren Quillian, Coral Gables .....	Daytona Beach, 1939
Pharmaceutical Association .....	Mr. R. Q. Richards, Ft. Myers .....	Mr. A. W. Morrison, Miami .....	Hollywood Beach, May, 1939
Public Health Association .....	N. A. Upchurch, Jacksonville .....	E. M. L'Engle, Jacksonville .....	Hollywood, Nov. 28-30, 1938
Radiological Society .....	H. O. Brown, Tampa .....	J. H. Lucinian, Miami .....	Daytona Beach, 1939
Railway Surgeons Association.....	Herman Watson, Lakeland .....	H. D. Clark, Ft. Pierce .....	Daytona Beach, 1939
Tuberculosis & Health Assn.....	Mr. G. E. Therry, W. Palm Beach .....	Mrs. May Pynchon, Jacksonville .....	Spring, 1939
Chattahoochee Valley Med. Assn.....	J. S. Turberville, Century .....	Frank K. Boland, Atlanta .....	Albany, Ga., July 11-13, 1939
Gulf Coast Clinical Society .....	J. H. Dodson, Mobile .....	C. C. Rouse, Mobile, Ala. ....	Mobile, 1939
Southeastern Derm. Assn.....	J. R. Allison, Columbia .....	Howard King, Nashville .....	Nashville, Sept. 3, 1939
Southeastern Surgical Congress.....	T. C. Davison, Atlanta .....	B. T. Beasley, Atlanta .....	Atlanta, Mar. 6-8, 1939
Southern Medical Association.....	Frank K. Boland, Atlanta .....	Mr. C. P. Loran, Birmingham .....	Oklahoma City, Nov. 15-18, 1939
Suwannee River Medical Society .....	E. C. Chamberlain, Madison .....	Eustace Long, Madison .....	



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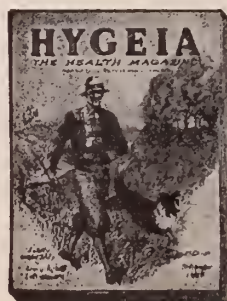
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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Dis- tricts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not In- cluded in First Column	Members	
						Total	Paid
Northwest District (A) Marianna 1939	Bay	W. J. Blackshear, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'40 Carol C. Webb, M. D., Pensacola	11	100%
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		44	43
	Walton-Ocalaosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		Santa Rosa	8	100%
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	16	14
	Leon-Gadsden-Liberty- Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	Calhoun-Franklin-Gulf	37	35
North Central District (B) Gainesville, October 27, 1938	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanche Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	17	14
	Madison	E. Long, M. D., Madison				4	3
	Taylor	Ralph J. Greene, M.D., Perry	W. J. Baker, M. D., Foley	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton- Lafayette-Suwannee	8	6
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M. D., McIntosh	28	23
	Marion	Carney W. Mims, M. D., Commercial Bank Bldg., Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	100%
	Pasco-Hernando-Citrus	Samuel C. Harvard, M. D., Brooksville	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		15	14
N. E. District (C) Palatka 1939	Sumter	Clyde L. Carter, M.D., Wildwood		2nd Tuesday	Bradford-Gilchrist- Levy-Union	5	100%
	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	161	147
	St. Johns	J. J. Spencer, M. D., 32 Saragossa St., St. Augustine	Vernon A. Lockwood, M.D., East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganious, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M. D., Daytona Beach	10	100%
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	39	37
	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St., Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	108	98
Southwest District (D) Lakeland, 1939	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	8rd Tuesday 7:00 P. M.		13	100%
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		89	100%
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		15	12
	DeSoto-Hardee-High- lands-Charlotte-Glades	L. W. Martin, M.D., Sebring	Howard V. Weems, M.D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M. D., Lakeland	21	19
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	11
	Polk	W. W. Shafer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Charlotte-Collier- Glades-Hendry	64	55
South Central District (E) Eustis, Nov. 10, 1938	Brevard	G. E. Christie, M.D., Titusville	I. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M. D., Cocoa	12	100%
	Lake	Harry T. Fenn, M. D., Mount Dora	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		18	100%
	Orange	H. A. Day, M.D., 209 Exchange Bldg., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		73	100%
	Seminole	J. N. Tolar, M. D., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	Osceola	13	100%
	St. Lucie-Okechobee- Indian River-Martin	R. C. Boothe, M.D., Ft. Pierce	Adrian M. Sample, M.D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	16	100%
	Broward	A. B. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M. D., West Palm Beach	31	100%
S. E. District (F) Ft. Lauderdale Oct. 13, 1938	Palm Beach	V. M. Johnson, M.D., Good Samaritan Hospital, W. Palm Beach	J. R. Sory, M.D., 616 Harvey Bldg., West Palm Beach	4th Monday 8:00 P. M.		56	55
	Dade	Arthur H. Welland, M. D., 227 Aragon Ave., Coral Gables	Claudio G. Mentzer, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	280	258
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		8	100%



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Florida Medical Association, Daytona Beach, May 1, 2, 3, 1939  
Southern Medical Association, Oklahoma City, November 15-18, 1938

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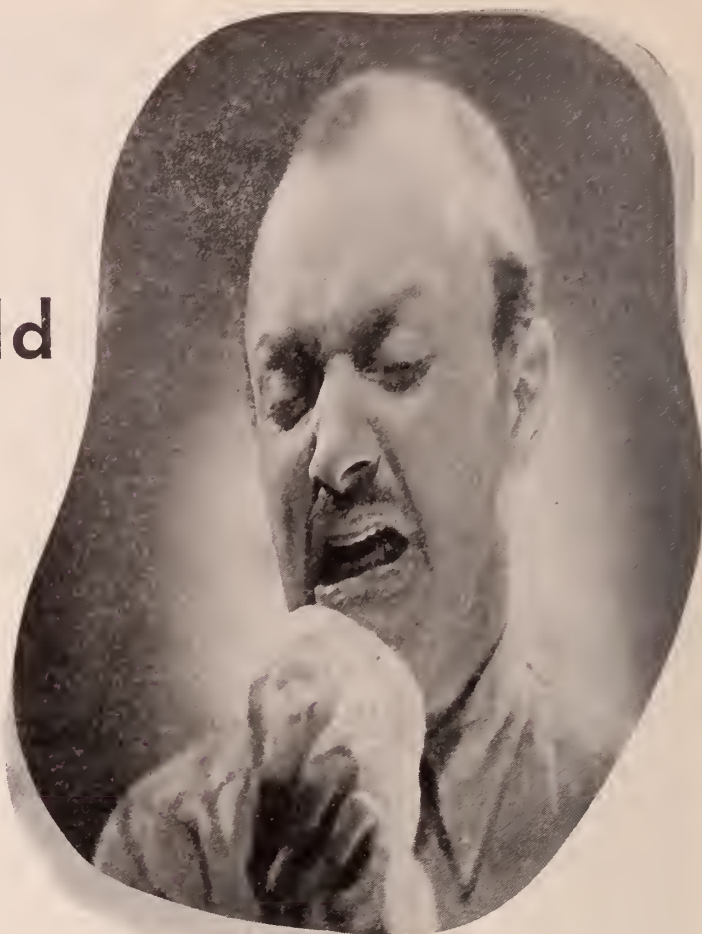
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## RECENT ADVANCES IN THE SCIENCE OF NUTRITION

### III. Some Attainments in the Fields of Vitamin A Research

● During the twenty-five years since its discovery, vitamin A has been the subject of much intensive research, first by the biochemist and physiologist, and later by the clinician and organic chemist. It may be of interest to describe briefly several of the achievements made in these various fields of research on vitamin A.

It has been found that vitamin A is unique among the vitamins thus far discovered. It is apparently the only vitamin produced solely by animal metabolism from precursors—certain carotenoid pigments—which are themselves solely the products of plant metabolism. The structure of the vitamin has been established and checked by syntheses of closely allied forms and probably of the pure vitamin itself (1).

Physiological and clinical researches have provided explanations of the mode of absorption of the vitamin and the mechanisms of transport and storage in the body (2). The specific pathological effects of varying degrees of vitamin A deficiency in humans have been extensively studied. Many of the older ideas concerning specific effects of vitamin A on man have been confirmed; some of the older beliefs have been dispelled (2).

Recent years have also brought improvements in assay methods for vitamin A (3). Common American foods have been sur-

veyed and their vitamin A values tabulated (4). Last but not least, authoritative estimates are at hand as to the quantitative requirements of children and adults for vitamin A (5). Such, in brief, are only a few of the important additions which have been made to our knowledge of this essential dietary factor. Today, students of nutrition favor the practice of "protective nutrition" in which the individual is maintained upon a diet calculated to supply all known dietary essentials—vitamin A included—in optimal amounts insofar as these amounts may be known. In specific instances, such dietaries must be supplemented by vitamin-rich materials. However, the prime consideration is to provide a properly formulated basic diet. In this connection, commercially canned foods are worthy of mention.

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1. 1938. J. A. M. A. 110, 1748.

2. 1938. Ibid. 111, 144.

1938. Ibid. 110, 2072.

3. 1938. Ibid. 111, 245.

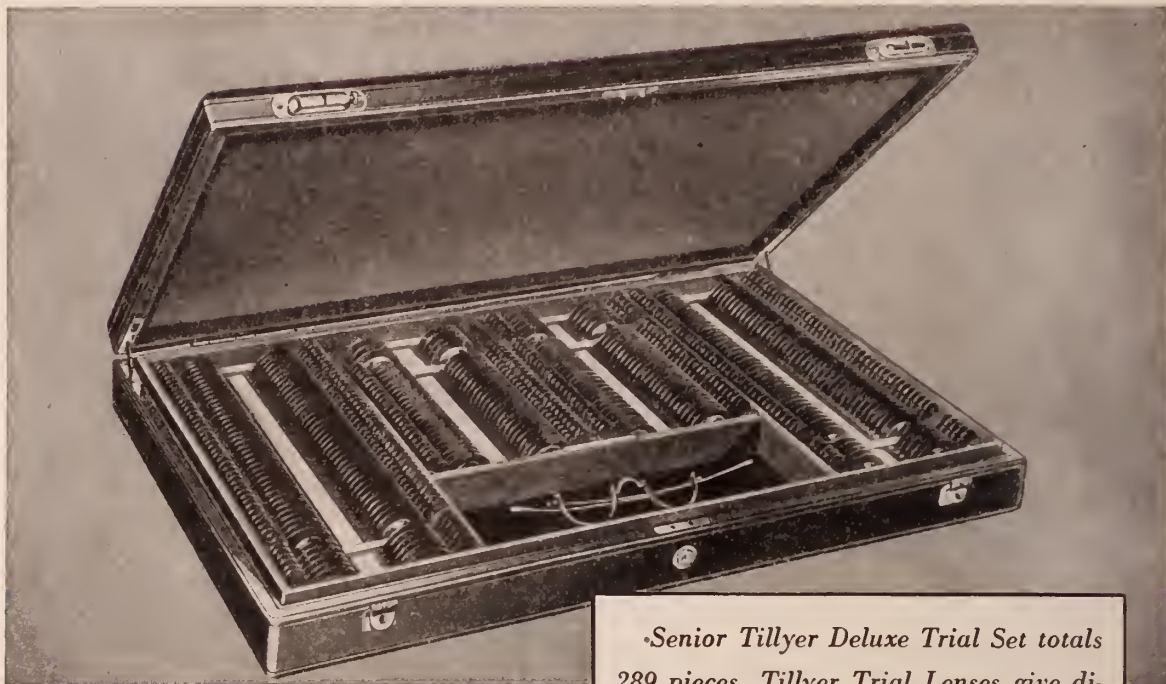
4. 1937. U. S. D. A. Bur. of Home Econ., Misc. Pub. 275.

5. 1934-1935. Amer. Pub. Health Assn. Year Book 25, 69.

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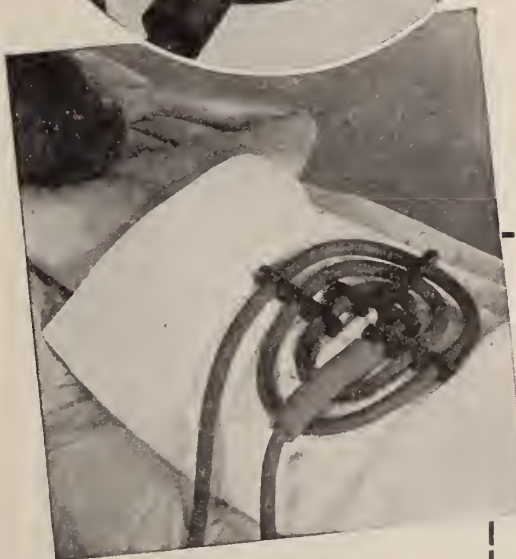
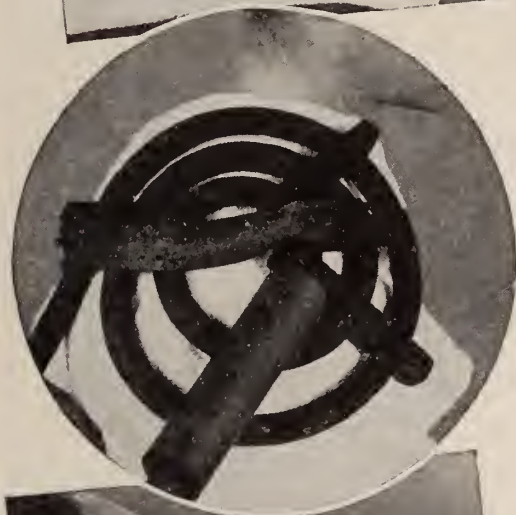
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## PREFRONTAL LOBOTOMY IN INVOLUTIONAL MELANCHOLIA

J. G. LYERLY, M. D.,  
Jacksonville.

Until a few years ago it was generally recognized that the prefrontal lobes of the brain were fairly silent as far as the localization of brain tumor, abscess, injury or other focal lesions were concerned. The only manifestations have been euphoria, facetiousness and personality changes. There has not been a distinct neurological syndrome as found in lesions involving the occipital lobe, precentral area, Broca's convolutions or the temporal lobes.

A resection of the prefrontal lobe has been done by most neurological surgeons for brain tumor without any serious handicap to the patient. Spurling<sup>1</sup> reported a case in which he resected the right prefrontal lobe in the case of a tumor which had already destroyed most of the left prefrontal lobe. Ackerly<sup>2</sup> reviewed this case in detail and reported that the patient's intelligence, reasoning and judgment were not disturbed and that the patient was relaxed and no longer seemed to worry. Brickner<sup>3</sup> reported a case in which there had been done an extensive resection of both prefrontal lobes in a man for brain tumor. His studies based on this single case would indicate there was considerable impairment of mental function resulting from resection of both prefrontal lobes. Fulton and Jacobson<sup>4</sup> in operations on the prefrontal lobes in apes found an absence of distractibility and the animal no longer went into a rage from his difficulty in carrying out a test problem as he did before the operation.

In 1936 Egas Moniz<sup>5</sup> attacked the prefrontal lobes by an operation he devised for the relief of certain mental disorders. He first injected alcohol into the prefrontal lobe tissue in an effort to sever some of the association tracts in the white matter. Later he attempted to section some of these tracts by means

of a leukotome which cut cores of tissue with a wire loop extending from a needle. He first recorded twenty cases and in a later article<sup>6</sup> stated he had done eighteen more. He found the best results were obtained in cases with severe states of anxiety, melancholia and depression. He also reported good results in certain cases of mania and schizophrenia. In 1937 Freeman and Watt,<sup>7</sup> following the operative technique of Egas Moniz, reported six cases of depression, agitation and anxiety states with improvement in most of them.

The operative procedure of Egas Moniz of cutting cores of tissue deep in the frontal lobe is a blind one and seems to me to be uncertain as far as knowing how many of the association fibres have been cut. Some of the failures reported by the authors might be due to an incomplete section of the association fibres of the prefrontal lobe connecting it with the rest of the brain.

I therefore have devised an operative procedure which will permit direct inspection of the subcortical tissue in the prefrontal lobe for section of the fibres of white matter, at the same time avoiding important vessels which might be encountered, and permitting the control of bleeding points as they occur. The operation is done on both sides through a transverse incision 3 cm. in length over a point 3 cm. lateral to the midline and 3 cm. in front of a perpendicular line above the tragus of each ear. This is the point of entrance as suggested by Egas Moniz which I have found to be satisfactory and well in front of the motor area. A button of bone is removed with a trephine and saved to be reinserted in the wound when it is closed, thereby preventing any depression or deformity in the contour of the skull. A small dural flap is made and turned back and the cortical vessels electrocoagulated along the line of proposed incision about one cm. in length. The incision is carried down through the cortex into the white matter. A brain speculum is then inserted and when the blades are separated a direct vision can be obtained of the white matter. By the use of a small dissector, a

Read before the Sixty-fifth Annual Meeting of the Florida Medical Association, held at Miami, May 9, 10, and 11, 1938.

transverse incision is made across the white fibres of the prefrontal lobe from the cortex on one side to the other, and as far as the cortex on the inferior surface of the frontal lobe. The incision is carried in front of the tip of the anterior horn of the ventricle, but should it pass through the horn of the ventricle it makes no serious difference. This operation cuts nearly all the association fibres in the white matter of both prefrontal lobes. The wound is closed by suturing the dural flap, replacing the button of bone and suturing the scalp in the usual manner.

The operation was done in 21 cases in all, from six weeks to nine months ago. Of these there were 14 cases of involutional melancholia, 3 of psychoneurosis with severe reactive depression and anxiety, 3 of severe depression of the manic depressive group, and one of severe depression and headache in a schizophrenic personality. The best results

were obtained in involutional melancholia and the reactive depressions with anxiety neurosis. As the title of this paper indicates, the case reports will be limited to involutional melancholia. It will be impossible to report all fourteen cases in detail. They will be briefly summarized in tables I and II and a full report made of the first two cases to show the clinical history typical of all these cases before the operation and the progress afterwards over the longest period of time.

In seven of the 14 cases of involutional melancholia operations were performed at the State Hospital at Chattahoochee, and the remaining 7 were done in private practice. Two of the case reports of involutional melancholia are herewith reported in detail.

#### CASE REPORTS

Case I. T. T., white, male, aged 59, a clerk by occupation, had as his chief complaint: mental depression. The family and past histories were essentially negative. He had had no serious sickness or operations.

TABLE I  
INVOLUTIONAL MELANCHOLIA PATIENTS OPERATED ON IN JACKSONVILLE

CASE NO.	NAME	SEX	AGE	DURATION OF SYMPTOMS	DATE OPERATION	DAYS IN HOSPITAL	INCONTINENCE	LBS. GAIN IN WEIGHT	RESULT
1	T. T.	M	59	6 mos.	6-19-37	28	0	15	Well 5 mos. 2 wks. Mild depression then well to present
2	R. S. B.	F	56	13 mos.	10-5-37	14	0	2	Apparently well
3	I. D. H.	M	47	22 mos.	10-5-37	15	0	42	Apparently well
4	T. C. A.	F	47	6 mos.	12-2-37	42	35 days	8	Apparently well
5	R. T. F.	M	51	4 mos.	2-2-38	25	0	20	Apparently well
6	I. M. T.	F	59	18 mos.	3-1-38	17	3 days		Apparently well
7	A. C. S.	F	59	12 mos.	3-25-38				

TABLE II  
INVOLUTIONAL MELANCHOLIA PATIENTS OPERATED ON IN CHATTAHOOCHEE

CASE NO.	NAME	SEX	AGE	DURATION OF SYMPTOMS	DATE OPERATION	DAYS IN HOSPITAL	INCONTINENCE	LBS. GAIN IN WEIGHT	RESULT
1	J. H. M.	M	47	9 mos.	11-29-37	Left Chatta. 40 days after operation	0		Apparently well
2	N. S.	F	48	10 mos.+	10-20-37		0	4	Greatly improved
3	H. G. McR.	M	56	6 mos.+	1-17-38	Left Chatta. 10 weeks after operation	2 weeks	32	Apparently well
4	B. R. B.	M	50	7 mos.	1-17-38	Left Chatta. 2 mos. after operation	0		Apparently well
5	E. W.	F	49	4 yrs.	2-14-38	Left Chatta. 2½ mos. after operation	0	3	Greatly improved
6	L. W.	F	53	7 mos.	2-14-38		0	9	Apparently well
7	A. E. H.	M	66	24 mos.	3-14-38		0	0	Apparently well



He had been married four times but divorced from all. There are three children living and well from his first wife.

The onset of the depression dated back six months, and was caused by worry about losing his job and not having any money. He then worried about everything in general, especially about how he treated his first wife. He had been very restless, afraid of having to go to jail, and had a fear of being beaten. There were ideas of reference. He talked of suicide, but had never attempted it. He tried to castrate himself while in a local sanitarium. He had been in the sanitarium for six weeks prior to examination. He would wring his hands and rub his head; pace the floor and could not keep quiet. He was depressed all the time.

Examination: The patient was fairly well nourished and developed. Neurologically the head, cranial nerves and functions of the lobes of the brain, and reflexes were normal. Blood pressure was 144/86. Mentally the patient was very depressed; he had a melancholic facies. He appeared to be older than he was. Memory and orientation were fairly good. Cerebration was very slow. He had to be induced to eat and talked very little. The laboratory examination including a blood Kahn was negative. Diagnosis was involutional melancholia.

Operation: June 19, 1937, a bilateral prefrontal lobotomy was performed and it was found that the pia arachnoid was slightly thicker than normal. There was a fairly large accumulation of fluid beneath. Nothing else unusual was found, nor any difficulty encountered in the operation.

Progress: The postoperative course was smooth. Highest temperature was 99.4 the day following operation; pulse rate was usually normal and several times got down to 60 while in the hospital. On the first day after the operation the patient was found lying awake with eyes open and alert, saying that he felt fine and was hungry. He never spoke of eating before, nor did he want to. He said he felt the same way about not having any work and he did not know how he was going to make a living when he got out of the hospital, but he was inclined to joke about it. He no longer talked of suicide. On the third day he was bright and alert, stating he was ready to go to work. He joked about being operated on for the relief of constipation. On the fifth day he continued bright and alert and there was no impairment of memory nor disorientation. He took more interest in things. The neurological examination remained negative. The wound healed nicely. He was bright and alert and cheerful on discharge from the hospital on July 17. On August 31, 1937, this patient walked in the office with a smile on his face saying he felt fine. He had no complaint, no depression, nor was there evidence of emotional instability. He had no abnormal ideas. There was nothing bothering him now as it did before. He was anxious to obtain more work. He was now working part time in a grocery store but he did not worry about not having more work. His blood pressure was 140/80.

On November 10, 1937, the patient came into the office and stated he felt nervous and somewhat depressed. He said he felt something like he did before the operation but not as bad. This was a recurrence of some of his former symptoms, evidently brought about by living and working around a tavern where there was considerable drinking and noise day and night which interfered with his rest. This condition lasted only two weeks and disappeared when he changed his work and place of living. On February 24, 1938, he came to the office looking bright, alert and smiling. He said he felt fine and never felt better in his life. He was now getting a steady job, and was very happy and enthusiastic over it. He had gained 15 pounds since the operation, and said he could eat anything. His bowels were regular, whereas he was constipated before. His memory and concentration were as good as ever. He felt like his

old self. He had no trouble with arithmetic, slept well at night, and said his ambition was to go to work. There had never been incontinence nor disturbance of bladder function. He was perfectly relaxed and there was no evidence of increased tension.

Case II. Mrs. R. F. B., aged 56, white, female, whose occupation was housewife, complained of mental depression.

The onset of her illness was 13 months previously with depression reaching its maximum in one month's time. Her worry started over financial matters, her husband being out of work, and daughter getting married. She was restless, nervous and greatly disturbed mentally. One month after the onset she was found in a closed room lying on the floor with the gas turned on, having tried to commit suicide. From this she recovered but remained in a depressed state; she could never see the bright side of things. Her physical condition became run down, and she was very anemic, refusing to eat. In October, 1936, she was examined by an internist who found evidence of pernicious anemia. She was given treatment for this and placed in a sanitarium for nervous and mental diseases where she remained until April, 1937. At this time her weight was only 82 pounds. The mental condition showed very little improvement. She was brought home and under the care of her daughter she was given forced diet and her weight increased to 100 pounds. It was the opinion of her physician, Dr. Karl Hanson, that the patient had a secondary anemia from improper diet. Since being at home she remained in the depression, was restless, agitated and walked the floor. She had been delusional and on several occasions accused her daughter of trying to poison her. She was afraid that all of her family would be killed or that something else dreadful was going to happen to them.

Examination: The patient looked somewhat anemic with her present weight of 100 pounds. Otherwise, the general physical and neurological examinations were negative. The memory and orientation were normal. The patient's expression was that of despair and depression. She did not talk except to answer questions. She was not seen to show any emotion at any time. She was only fairly cooperative. Her blood pressure was 102/68.

A diagnosis of involutional melancholia was made.

Operation: On October 5, 1937, a bilateral-prefrontal lobotomy was done. No unusual findings nor difficulty was encountered, other than considerable collection of subarachnoid fluid.

Progress: On the first postoperative day the patient was brighter and more alert than before. There was no motor weakness nor speech difficulty, and the neurological examination remained negative through the course. There was occasional vomiting, which lasted two days. The highest temperature was 101 per rectum. On the second postoperative day she was found sitting up in bed, reading and smiling. She was very responsive and talked readily. Her memory was good. On the third day she appeared to be embarrassed because she did not have her false teeth when the observer walked into the room. She began asking questions about herself and her operation. She began taking interest in things and readily ate the food which was brought to her. There were no signs of worry nor apprehension at any time.

On her discharge from the hospital fourteen days after the operation she was walking about, cheerful, laughing and joking. She has reported at the office several times since then. On November 22, 1937, it was noted that the patient had no impairment of memory or disorientation. She was intelligent and all of her responses were normal. She smiled in a cheerful manner. Her sister came with her, and stated she was an entirely changed person from what she was before the operation. She no longer worried about anything. Within a week after leaving the hospital she came to

my office by herself and asked for permission to go to an entertainment at the Woman's Club the following day. She stated she no longer felt nervous or worried. Her appetite was good. On March 17, 1938, the patient walked into the office, smiling, radiant. She said she felt happy and never better in her life. She enjoyed going places, and attended the Woman's Club frequently. She had been visiting relatives in Georgia. She had been doing her own house work and did not feel nervous nor under tension as she did before; did not have the worried and hopeless feeling she had previously. Her weight was 102 pounds.

The above two cases are illustrative of the fourteen in the involuntional melancholia group. In the first case there was some recurrence of the depression lasting two weeks. This recurrence was not observed in any of the other cases. It was felt at the time that this being the first operative case, the operator probably did not cut all or sufficient of the association fibres in the prefrontal lobe. A reoperation was being considered in view of the excellent results obtained in subsequent cases when the patient recovered from the depression and continued to remain in a normal and happy state of mind.

In no case has the patient died nor has there been any serious complications resulting from the operation. There was some slight impairment of memory and disorientation with mental confusion lasting a few days to a few weeks, but in every case it cleared up entirely before the patient left the hospital. In no case did it appear to affect the patient's judgment, reasoning, or concentration, or his ability to do arithmetic. In one case there has been a tendency to use indiscreet language only under stress. Most of the patients stated they could think better and do more work than before. Their appetites were better and nearly all of them gained weight, in one case as much as 40 pounds. In a few cases there was some involuntary urination lasting a few days while at the hospital. In no case were there any complications following the operation, such as hemorrhage, paralysis, aphasia, or other objective neurological disturbance. Most of the patients returned to some form of occupation. Four of the seven involuntional melancholia patients operated on at the State Hospital at Chattahoochee have been discharged to their homes, and no doubt some more of them already operated on will be discharged as soon as sufficient time has elapsed to determine whether the improvement will continue.

I am indebted to Dr. William McCullagh for the psychiatric study in most of these cases, also to Dr. Ralph Stevens and his staff at the Florida State Hospital for their help in making this report possible.

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#### DISCUSSION

*Dr. J. C. Davis, Quincy:*

Doctor Lyerly is to be commended in devising a new operative procedure which permits visual section of the association fibres of the prefrontal lobe, connecting it with the rest of the brain. It can readily be seen that this operation has many advantages over the blind operative procedure.

The significance of this operation is that hope for recovery is now held out to cases of involuntional melancholia and reactive depression with anxiety neurosis. Each case of involuntional melancholia in which Doctor Lyerly operated at the Florida State Hospital, the patient has either been released or is ready for release. Results obtained have been nothing less than miraculous. An immediate improvement was noted in all cases the day following operation. There were no deaths, no complications, and very little discomfort experienced following the operation.

Words are inadequate to describe the mental torture that these patients with agitated depression experienced before operation. For that reason the value of the prefrontal lobotomy, estimated in terms of relief of human suffering, cannot be overrated.



One observation that might well be pointed out is that the men operated upon appear to recover more quickly than the women. However, this is also true in most operative procedures, and in view of the small number of operations at the State Hospital thus far, too much stress should not be placed on this factor.

Our state mental institution is fortunate in numbering Doctor Lyerly on its visiting staff, and in looking forward to a future in which his services may enable us to release patients for whom formerly we could hold out very little hope of recovery.

*Dr. P. L. Dodge, Miami:*

This paper is tremendously interesting to me, and I want to congratulate Doctor Lyerly upon his rare work in this line. There is not any type of case that we see, those of us who handle nervous and mental patients, that is quite as depressing as involutional melancholia and agitated depression. No matter what we do from a psychiatric standpoint there is very little that we can accomplish. Giving them all of the various injections of clinical therapy does not seem to accomplish anything and the condition goes on. The patient is still agitated and still depressed, refusing to eat, losing weight, losing strength and becoming more and more deteriorated until he finally gets into an institution. I think there is nothing more depressing in all the field of nervous and mental diseases than is this particular type of patient.

The fact that Doctor Lyerly has found this particular operation has helped this very small number of cases should stimulate every one who sees these cases to think of the possibility of helping that particular patient. Of course, it is still in its more or less experimental stage without a great many cases to back it up, but with the success he has shown we should all be willing to cooperate with him in this particular advancement to see if we cannot bring it before the rest of the world for the benefit of every patient who suffers from this disease so that they might avail themselves of this particular operation.

I have a number of cases now and I am going to write and see if I can possibly induce the relatives and friends to take this chance because the patients are deteriorating, and they

certainly will go on like such cases have gone for centuries past. I was in the New York City Hospital for a number of years and I saw hundreds and hundreds of these patients who just deteriorated. They were absolutely hopeless and helpless. If we can possibly help them I certainly will be very glad to endorse it.

I want to again congratulate Doctor Lyerly.

*Dr. J. G. Lyerly (concluding):*

I want to thank the doctors for their discussions.

I would like to state again that this is only a preliminary report. We do not know how permanent the relief will be but it seems to me that it stands to reason that if you sever these association fibres in the white matter of the brain there should not be any recurrence and it should be permanent. But it will take time to determine whether there will be any return of the depression.

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## INSULIN SHOCK THERAPY AT FLORIDA STATE HOSPITAL

A. L. Huskey, M. D.,  
Chattahoochee.

Since Sakel discovered some five years ago that repeated hypoglycemic states tended to improve patients suffering from schizophrenia, there has been widespread use of this therapy. In the past several months much literature has been published on the subject, attesting to the fact that the therapy is now being used rather extensively by the more progressive observers of mental cases.

Insulin shock therapy was introduced at the Florida State Hospital in September, 1937, after the writer had spent six weeks observing this treatment at the Elgin State Hospital. Several weeks are required to complete administration of the therapy and only a few cases can be handled at a time by one physician. This paper makes no claim for original findings. It is intended merely to state the nature of the therapy and the results that have been obtained thus far at your state institution.

Six patients are treated at one time, this being the average number to whom one phy-

Read by title before the Sixty-fifth Annual Meeting of the Florida Medical Association, held in Miami, May 9, 10, and 11, 1938.



sician can give attention. There is one full-time nurse and one attendant. The patients are given an intramuscular injection of insulin at 7:30 a. m., on a fasting stomach. The initial dose of 10 or 15 units is increased by 5 to 10 units daily until a shock dosage is reached. The patients react more favorably and a shock dosage is more easily determined if the "build up" is prolonged by small doses rather than increased rapidly by large doses.

After a shock dosage is determined the patients are shocked daily except on Sunday. They are carried through the four phases adequately described in the literature,<sup>7</sup> and are treated until a recovery is effected or until it is thought the patient can receive no benefit from the therapy. The average patient reacts in from 20 to 40 shocks, the smallest number of shocks in this series being 7 and the largest 90.

All patients treated in this series carried a diagnosis of schizophrenia. All were young, physically healthy males under 30 years of age. It is probable that the duration of the psychosis was not accurately determined because inconsistencies always occur in the histories of mental cases. Following the patient's mental break, the parents often recall for the first time some peculiarity following a trivial childhood injury. To this they attribute the origin of the patient's psychosis. With this taken into account, as best we could determine, the duration of the psychoses in this series ranged from two months to seven years.

While the patient is in shock, constant observation is required to detect impending dangers. A well trained nurse is invaluable in this connection. The amount of insulin required is never related to the size of the patient. One of the youngest and lightest in the group required the largest dose. As the treatment progresses the shock dosage is rarely constant. The dosage is determined by the depth of the coma the preceding day. Some patients develop a tolerance for insulin during the course of the treatment, but more often develop a sensitivity. In one case the original coma dosage was 205 units. After four weeks of treatment the coma dosage had dropped to 100 units.

Controlling the depth and length of each coma is really the difficult part of the therapy.

It is generally believed best to carry the very depressed patients to a highly excitable stage and there to interrupt. The hyperactive ones are usually put in deep coma and allowed to remain there for some time before interruption. This has been recommended by several observers. There is, however, no definite rule to follow and only through close and careful observation may the depth of coma desirable in any individual case be determined.

#### THEORIES AS TO THE ACTION OF INSULIN

Much has been written concerning the way in which insulin acts in cases of dementia praecox. All explanations advanced thus far are merely theories. A few of the outstanding theories may be mentioned. One of the early explanations was that when insulin caused a state of coma there was a decreased glucose content of the cortical cells. This greatly depressed the abnormal pathways which in schizophrenia had gained superiority over the normal pathways. In a return to consciousness during the euphoric stage there was a tendency for the normal pathways gradually to gain superiority over the abnormal pathways.

There is also the gaseous imbalance theory described in the literature.<sup>14</sup> It has been demonstrated that there is a slightly low oxygen content of the blood in long standing schizophrenics. In insulin shock the oxygen content of the blood has been shown to be actually increased during coma. It is possible that insulin shock tends to correct the gaseous imbalance.

Recently there has been pointed out the well-known fact that fasting persons are more alert mentally than persons who have had regular full meals. There is possibly an analogy between this type of fasting and the starvation in insulin coma. It is generally recognized that no pathology can be demonstrated in the central nervous system by postmortem examination of schizophrenics. There may be, however, some biochemical change present which as yet has not been demonstrated. Recent work in the examination of the brains of rabbits dying in different stages of hypoglycemia has shown actual microscopic changes.<sup>16</sup> If the rabbits died during a convulsion there was liquification, vacuolation, and homogenization of the ganglion cells. If they survived and were later killed and examined,

a marked shrinkage of the cytoplasm and nuclei of these cells was noted. These changes tend to support the theory that hypoglycemia does produce a biochemical or possibly a histologic change in the brain cells of schizophrenics. If this observation proves that there is an actual histological change in brain cells of insulin treated patients, it may be the explanation of the mode of action.

The writer offers no new theory as to the mode of action of insulin. It is thought, however, that too little stress has been placed on the attendant psychology in treatment of the patient.

Because of the crowding and shortage of trained workers in a large public mental institution, the environment is not especially desirable for the average mental patient. In this series of patients it is felt that applied psychology and environment has played a great part. These patients lived under the best conditions that we could afford them. In selecting each case, the writer had a long talk with the patient personally. In every case he was fortunate enough gradually to gain the confidence of the patient. This is vitally necessary to the success of the therapy.

After the treatment is under way, personal contacts are made frequently. Early in the course of the therapy all delusions and other mental abnormalities are discussed. As the treatment progresses these are less frequently referred to and when mentioned they are passed by lightly and it is suggested that they were imaginary. Finally toward the end of the therapy the patient usually agrees that these ideas were a product of his imagination. He is then told never to think of these abnormalities or his past experiences in this connection, but to live from this time onward. It is believed that this suggestive psychology greatly aids in effecting an improvement.

This report consists of 15 cases in which treatment was completed. There are six patients still under treatment. In tabulating the results obtained the cases have been divided into four classes. They are:

1. Greatly improved. These are the patients who showed no psychotic residuals and are ordinarily spoken of as having a remission.
2. Moderately improved. These patients had some psychotic residuals but were able to make a social recovery.

3. Slightly improved. These are the patients who were somewhat quieter if in an excited state or more cheerful if in a depressed state. They retained most of their psychotic trends but were able to repress them somewhat. Not expected to make a good social adjustment, they were furloughed only if the relatives insisted.

4. Unimproved.

The results tabulated according to the classification are as follows:

CLASS	NO. OF CASES	PERCENTAGE
Greatly Improved.	5	33 %
Moderately Impvd.	3	20 %
Slightly Improved	5	33 %
Unimproved . . . . .	2	14 %

As has been shown in the literature, the cases of recent onset showed the most improvement. In all cases showing great improvement the psychosis was of less than one year's duration. In the moderately and slightly improved group the psychosis had lasted from one to seven years, while in the unimproved cases the psychosis had lasted from two to seven years.

The writer did not get the often-reported high 80 per cent remissions in the patients with a psychosis of less than one year's duration. The reason for this may be two-fold. There is a strong possibility, as before stated, that the history is inaccurate. It is a well known fact that most people have a morbid dread of a state mental institution. Therefore, most patients have had a psychosis for some time before admission, having been sent to a state institution as a last resort. Another reason for the lower percentage of remissions is that it is believed that some reporters have been too enthusiastic about the therapy. It is the writer's belief that the reported 80 per cent remissions in recent cases will prove to be too high with routine use.

Every patient in this group has been furloughed from the institution. The guardian was told the exact condition of each patient and was instructed how to care for him. There has been only one who returned to the institution thus far. One of the unimproved patients was sent to another mental hospital, however. The others are apparently well adjusted, and

every member of the greatly improved group is gainfully employed. We receive monthly reports from the guardian of each patient, and all of these reports have been highly satisfactory and gratifying.

Every patient in this group evidenced much physical improvement. All gained in weight, the gain ranging from ten to thirty pounds. One other very noticeable physical improvement was in skin lesions in three patients and in the general skin condition of all. Three cases of moderately advanced acne were seen. After termination of the treatment two cases were entirely healed and the third greatly improved. In all the other patients the skin became much smoother and more elastic. This therapy could not, however, be recommended for skin disease, *per se*.

Each patient referred for insulin treatment was tested with the Stanford-Binet intelligence examination and the scaled information test by our psychologist before and after administration of the therapy. Data on the behavior of the patient during the examination were also recorded. As this experimental testing is still being conducted, and as the results are numerically insufficient, no definite conclusions have been formulated. We are primarily interested in determining the degree of impairment of learning efficiency or deterioration before and after the therapy, and in seeing whether these quantitative measurements are in accordance with staff opinion as to the patient's condition. Results indicate not only a change in the degree of impairment or deterioration but the mental ages secured on retesting have also altered. It may be that improvement should be partly attributed to practice effect, but in most cases where the increase in mental age is very marked it may be ascribed to a change in the patient's mental condition resulting in an increased learning efficiency and power of attention. In the near future a detailed analysis of individual scores will be compiled, making use of the follow-up results in those patients who have been discharged or furloughed.

There have been no fatalities in the group of patients given the insulin shock therapy at the Florida State Hospital. The relatively low mortality in this type of properly supervised therapy should be of interest to all general practitioners. It proves that we need no

longer fear, as we once did, that we might have a death from hypoglycemia in diabetic patients given too much insulin accidentally. Even if a patient does get muscular spasms and goes into a semi-conscious state he will probably always come out of it in a short time and be able to ingest glucose. This is explained by the fact that the excess adrenalin thrown off liberates some of the stored liver glycogen to care for the exigency.

There were few complications in this group and all were of the general type reported in the literature. There was a total of 13 convulsions. None of these were particularly alarming. Usually the patient would come out of the convulsions and rest quietly thereafter. If his condition did not seem satisfactory he was given glucose by tube feeding. It is considered necessary to resort to intravenous glucose as a form of interruption only in the event of cardiac collapse, complete laryngospasms or acute pulmonary edema.

One of the patients sustained a fracture-dislocation of the shoulder joint, due to muscular violence. The patient was in light coma and put up so much resistance to nasal tubing that this accident occurred. The only severe complication was one case of extended coma. This patient did not react until thirty hours after interruption, presenting muscular twitching with cardiac and respiratory embarrassment for almost the entire period. Upon coming out of coma he changed from a very depressed type to a hyperactive type. The treatment was not carried further in this case. Very little attention was given to the difference between the wet and dry type of coma. In reality a thoroughly dry coma was not seen. All were varying degrees of wet coma. It was noted that the more profuse the perspiration the greater the gastric and buccal secretions.

In closing it would not be amiss to mention the metrazol treatment of dementia praecox by way of comparison with insulin. Metrazol is a synthetic cardiac and respiratory stimulant which causes convulsions when given intravenously in large doses. Some few cases have been given this therapy at the Florida State Hospital. In the cases treated the results have not proved quite as encouraging as the insulin treated cases. It is believed that with improved technic it will compare very



favorably with insulin shock therapy, as it has the advantage of requiring much less time for administration, and a less experienced staff.

It is realized that no definite conclusions can be drawn as to the efficacy of the therapy with such a small number of cases. Yet with the limited experience gained with this series, and after a consideration of all the literature, it is deduced that insulin shock therapy is certainly not a panacea for the mental states diagnosed dementia praecox. It is believed, however, that it is one step nearer the discovery of a more effective therapy for this baffling malady. It is certainly the most progressive advance made in recent years. The administration of the therapy is complicated. Nevertheless, it is believed that selected schizophrenics of recent onset should have the benefit of this treatment until ever-advancing medical science can offer something better.

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#### ACUTE CONDITIONS WITHIN THE ABDOMEN

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As we pass down through the years of practice, we eliminate many views, strengthen others, while experience will cause us to formulate many new ideas.

The subject of this paper, encountered daily, causes us to make, break, and change many of our views. Acute conditions within the abdomen, with the problem of diagnosis, may be likened to a swiftly moving drama, exciting the emotions of relatives, and taxing the reasoning powers of the surgeon to the utmost. Action at the proper time brings cure to the sufferer in most conditions, while delayed action and indecision result in hopeless tragedies.

Here, it might be well to emphasize the use of four of our five senses—sight, smell, touch and hearing. Note the way that the patient comes into the office, or the way he lies slumped in his bed. He probably doesn't notice that you have entered the room—he is sick. His weakened voice and pulse denote lowered vitality. His face which may present anxiety, the coated tongue, knees drawn up, at once suggest an acute peritoneal condition. Find time to take a very complete history. It may help to determine whether you are dealing with acute cholecystitis or ruptured ulcer. At the same time, remember the former is three times more common in women, while the latter, in the same ratio, more common in men.

Remember that the "acute" abdomen may be a simulated or true entity; simulated as in pneumonia or pleurisy, with referred pain or, as in coronary disease or angina, often referred to the area of the gallbladder. Pain that has been continual for several hours

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points to trouble within the abdomen, while a lack of tenderness for the amount of rigidity, slow pulse, and a more comfortable facies serve to warn us not to be too sure of an abdominal lesion.

Here we should recall some of the non-surgical causes of abdominal pain:

1. Metabolic, as in diabetic acidosis and tetany.

2. Cardiovascular, as in angina pectoris, coronary occlusion, pericarditis, embolism, thrombosis, intra-abdominal arterial disease, e.g., periarteritis nodosa and dissecting aneurysm.

3. Hematologic, as in hemolytic icterus, Henoch's purpura, sickle cell anemia, infarcts and enlargement of the spleen.

4. Gastro-intestinal, as in acute gastroenteritis, of food or metal poisoning, pylorospasm, cholangitis, intestinal parasites. The latter may produce a complete surgical obstruction.

5. Infections, as in malaria, influenza, poliomyelitis, amebic or bacillary dysentery, crises of tabes dorsalis and arachnoidism (black widow spider bite.)

6. Genito-urinary, as in pyelitis, Dietl's crisis, bladder distention.

7. Pulmonary, as in pleurisy and pneumonia.

8. Disorders of the abdominal wall, as in herpes zoster before the appearance of the eruption, intercostal neuralgia, trauma, trichiniasis.

9. Malingering and hysteria.

Many of these conditions will tax our diagnostic acumen, but this is something we must cultivate more. We are too easily led by a laboratory report. I do not wish to disparage its importance, but rather to enter a plea for more painstaking clinical study.

One of the conditions mentioned above, because of its importance locally, should be discussed in more detail, namely, arachnoidism. The symptoms begin with acute onset of severe pain, which occurs within a few minutes to three or four hours after the bite of the spider. With the onset of severe cramp-like intra-abdominal pain, frequently associated with nausea and vomiting and extreme board-like rigidity of the abdominal wall, it may easily be confused with perforated peptic ulcer. Of assistance in differentiation is the as-

sociated pain or ache in the muscles of the thighs and back, and the lack of marked tenderness that accompanies a perforated hollow viscus. Where the abdomen has been explored in this condition, nothing abnormal was found except a spasm of the entire intestinal tract, an enterospasm.

Case. Only a few nights ago I was called to a ten months old baby who was crying, nervous, jumpy. The abdomen was rigid and drawn as if in a cramp. Upon completing the physical examination, I discovered a swollen right index finger and right forearm. Inquiry brought out the fact that the child had played in the yard about two hours earlier and that while there, two black widow spiders had been seen, but had escaped.

When the "acute" abdomen is a true entity it presents visible pathology within the abdominal cavity. Acute appendicitis is the most common cause, also cholecystitis, perforated gastro-duodenal ulcer, intestinal obstruction, acute pelvic conditions, ruptured extra-uterine pregnancy, twisted ovarian cyst, pancreatitis, trauma, acute diverticulitis.

A review at this time of the sensibility of the peritoneum will no doubt assist us in diagnosing the above enumerated conditions. Pain is a warning that all is not normal. The parietal peritoneum is supplied by the cerebral nerves, hence the parietal peritoneum possesses a very accurate localizing sense. The intestinal tract is supplied with two plexuses of the sympathetic and its response is due to distention; hence the abdomen presents two classes of pain, one due to irritation and the other to distention. We may do almost anything with the hollow viscera, so long as we avoid stretching the plexus within the gut wall, or putting traction on the nerves to the semi-lunar ganglion. Irritation of either induces pain. In absence of an exudate, simple hyperemia, active or passive, does not induce pain.

Morphine as a diagnostic agent: Following the above deductions, Alexander, quoting Ziebold at Mayo's, says that if the abdomen is rigid and tense, palpation of the affected viscus cannot be satisfactorily done. Therefore if as in appendicitis, the cerebral cortex is inactivated by morphine, Payne says  $\frac{1}{4}$ ,  $\frac{1}{2}$  or 1 grain, producing a loss of general abdominal spasm, i.e., a loss of tenseness and rigidity without abolishing the spinal reflex, the spasm of the affected viscus can be palpated and often defined. This works conversely. In coronary disease, if there be no



intra-abdominal lesion, then the spasm disappears. The degree of error checked by the same observers was 15.3%.

The time of onset of pain may furnish a clue to the diagnosis. Appendicitis often comes on in the early morning hours, awakening the patient from a sound sleep. Biliary and renal stones seem to prefer the midnight hours. Perforated ulcer pain most often follows a meal, while ruptured tubal pregnancy or twisted pedicle of ovarian cyst follows exertion.

Acute appendicitis: This is responsible for 50% of the emergency intra-abdominal conditions. When the appendix is in the normal position, i.e., McBurney's point, in the beginning the pain is rather vague and diffuse about the umbilicus or epigastrium, so long as the involvement is within the lumen, but when the inflammatory process extends to involve the parietal peritoneum, the pain becomes localized. At this stage, there may be nausea, vomiting and constipation, slight fever and leukocytosis.

If the appendix is retrocecal, the pain is localized in the loin from the beginning, due to its contact with the abdominal peritoneum. If in the pelvis it often gives only rectal tenderness. In other cases, the pain is never localized, or is referred to the nearest peritoneal surface. Pain that comes on rather suddenly and persists constantly over the appendix is usually due to obstruction of the lumen near the base by fecal concretions. This type tends to rupture early.

Acute appendicitis that occurs during or just after a pharyngitis, tonsilitis or other acute respiratory infection is usually fulminating, therefore demands early intervention. With the infant and child, a diagnosis is often quite difficult and we should not forget that up to four years of age, the blood shows a relative lymphocytosis.

The unruptured, so-called clean appendix, presents no great problem, but the proper management of the ruptured appendix is a serious problem on account of its sequelae as peritonitis, local abscess, sepsis, etc.

Acute gallbladder disease: A carefully taken clinical history is the best aid to a diagnosis with the aid of duodenal drainage and x-ray. According to T. G. Miller, 15%

of the population of the United States has or has had gallbladder disease and autopsy records after the age of 45 years show 30% to have calculi, and 60% to have disease of the biliary tract. All acute obstructive cases should be placed in the emergency class. Early operation forestalls liver damage, pancreatitis and peritonitis.

Peptic ulcers: The mortality rate in this country and abroad runs from 24% to 45%. Delayed diagnosis means delayed surgery, and delayed operation means a high mortality rate. Even where operation is performed under six hours, it is 7.5%. This figure seems high, especially in the face of the fact that 80% of all perforated ulcers have given symptoms for from six months to five years. During the ulcer stage, limited to the mucosa and submucosa, we remember the ulcer triad, hunger, pain with food ease, and periodical attacks. Hemorrhage occurs in 30% of all duodenal ulcers. Lahey observed that 40% of the first hemorrhage cases, and 83% of the second hemorrhage cases require surgery. Acute perforation causes agonizing pain, often referred to the shoulder, and at the same time nausea and vomiting, with board-like rigidity of the abdominal muscles. There is some degree of shock and the slighter the shock, the nearer normal is the pulse. Shallow respiration, tenderness of pelvic peritoneum and presence of gas as shown by a flat x-ray plate, will assist in arriving at a diagnosis.

Obstruction: The presence of abdominal pain, nausea, vomiting and constipation without fever and leukocytosis, coupled with a competently interpreted flat x-ray should help make a diagnosis often times before the elevation of temperature, leukocytosis, distention and profound blood changes have taken place. In the beginning the pain is recurring, cramp-like with borborygmus. If the obstruction is located in the small bowel, there is frequent and copious vomiting, the duodenal tube evacuates yellowish brown fluid, and later there is vomiting of feces; while with large bowel obstruction, vomiting is rare, even when there is complete obstruction and the stomach is empty.

The mortality rate is high, due to delay in diagnosis and institution of proper treatment. In the earlier hours when it is simple obstruction, relief of the obstruction may be all



we have to do, but when strangulation and toxemia are added with the coincident blood changes, we are facing a graver problem. Here we must give proper preoperative preparation, by replacing lost fluids, chlorides and glycogen, where there is evidence of dehydration or, if indicated, give a transfusion.

In children, we are often confronted with low grade abdominal pain. Intussusception is to be suspected when coupled with bloody stools and a palpable mass. We might bear in mind to expect intussusception during infancy and early childhood; hernia and peritoneal adhesions in early adult life; and carcinoma in late adult life. The old advice, "Never let the sun go down on a case of intestinal obstruction," is good.

Ruptured ectopic pregnancy: The onset is sudden, usually as the woman goes about her household duties, manifested by sudden abdominal pain, sometimes nausea, faintness, pallor and collapse. The body surface is cold, temperature subnormal, pulse rapid and thready. In some cases there is very great shock, out of proportion to blood loss. Here we must often treat conservatively rather than surgically. Primary hemorrhage does cause death in these cases; so does added shock by too hasty operation. The blood count is unreliable for estimating blood loss. Here blood transfusion is often a life-saver, especially if operation must be done in the face of adverse conditions.

Acute pelvic conditions: In the female, these are usually acute pelvic cellulitis, sometimes only an acute salpingitis. Often these cases are confused with acute appendicitis. However, the majority of them do not present the very grave symptoms of the "acute" abdomen; therefore may be treated expectantly.

Diverticulitis: The symptoms of inflammation of Meckel's diverticulum and of diverticulae located elsewhere will often simulate an acute appendix or gallbladder. The complications that demand surgical relief are perforation with peritonitis, abscess, and obstruction. These diverticulae are more common in the descending colon. X-ray is of great assistance in diagnosis.

Pancreatitis: There are no pathognomonic symptoms, the more common being vomiting and collapse, with pain radiating from the right costal border across the upper abdomen

and tenderness over the course of the pancreas which should direct our attention to the preponderance of symptoms at or above the umbilicus.

I must add another chapter to the common causes of "acute" abdomen, namely trauma. The large number of automobile accidents are bringing cases of this type. Any organ or viscus within the abdomen may suffer any degree of traumatic damage. Note bruised areas on the body. They may give valuable clues to a deeper-seated injury. Note the degree of shock, the pulse rate, blood pressure, temperature and respiration. A urinalysis may reveal kidney, ureter or bladder damage. X-ray often gives valuable returns. Perforating injuries call for immediate intervention. All operative aid should be rendered in six hours or less, if possible. If you cannot determine the nature of the damage, then follow the advice of Maes of New Orleans:

"Don't wait to see, but look to see."

A word should be said about trauma produced by the surgeon doing undue exploration. The more the viscera are handled, the greater the postoperative shock and suffering to the patient. A simple enteritis where the abdomen has been opened by a mistaken diagnosis may be converted into an acute peritonitis. A ruptured or abscessed appendix is often best let alone with a drain until the temperature has become normal. Attempt at removal at the height of the inflammatory process is sure to bring sad results in far too many instances.

Very briefly I have reviewed the more common conditions causing acute surgical conditions within the abdomen. I have tried to stress clinical study and early diagnosis.

In closing, I might say a good general rule would be to regard a case of pain, nausea, vomiting, with constipation, for six hours as having a surgical background, unless you are able to prove it otherwise.

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## COMPLICATIONS FOLLOWING CAUTERIZATION OF THE CERVIX

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Major complications after cauterization of the uterine cervix are few and far between. This statement is based on a survey of the literature to date. The number of major complications that have followed the use of the cautery in my small practice leads me to believe that they are far more frequent than the literature indicates. These complications have been reported by Cannell and Douglass,<sup>1</sup> by Hiller,<sup>2</sup> Curtis<sup>3</sup> and by Masson and Parsons.<sup>4</sup> The use of the cautery is so widespread that an analysis of the recorded cases and of two cases of my own should be of some value in arriving at some contraindications to its use. The two cases reported by Hiller both gave a history of previous criminal abortions and his conclusions were that a history of a septic abortion must be considered as a definite contraindication to coagulation treatment of the cervix. Cannell and Douglass state that their complications have followed cauterizations

with the heavy duty or the postcautery. Curtis felt that these complications were perhaps more common in those women who have a retrodisplacement of the uterus. In the three cases reported by Cannell and Douglass the probability of a flareup of a residual salpingitis was very strong. In one of the cases reported by Cannell and Douglass the patient had had a previous criminal abortion. Their first case was an acute tubal inflammation following cauterization and was verified by operation. The second case was a cul-de-sac abscess in a patient who presumably had an attack of salpingitis two years previously.

The lymph drainage from the cervix is mainly into the base of the broad ligament and from this point into the lymphatic chains along the great vessels. An infection from the cervix traveling through the lymphatics should involve the cellular tissue of the broad ligament and from there extend retroperitoneally upward.

Cannell and Douglass quote Curtis as follows: "Reticence in discussing unfavorable results in cauterization has perhaps tended to conceal the true incidence of complicating cellulitis. Nearly all with whom I have discussed this subject state that they have had cases of pelvic cellulitis in patients subjected to endocervical cauterization."

The paucity of reports dealing with this complication is unfortunate as perhaps an exhaustive study would bring to light some definite contraindications for cauterization of the cervix. The cautery is a very effective treatment for nearly all cervical infections and its use is so widespread that certainly study will bring to light some method of anticipating or preventing these crippling complications.

I could find no reports of a case with an abscess in the broad ligament which was drained extraperitoneally above Poupart's ligament. The extension of the process was similar to that of a postabortal or postpartum parametritis. It was treated along the same lines as if it were a postpartum parametritis. It is an unusual case, the report of which I hope will not deter anyone from doing a cauterization. Cauterization is so valuable that I was hesitant to make this report. I thought that it might prevent some doctor from cauterizing a cervix in which cauterization was indicated.



In the following case there was no history of a previous abortion, septic or otherwise; no history of any pelvic inflammatory disease or retrodisplacement. The only point in the history was intermenstrual pain occurring two weeks after the onset of each menstruation. The cauterization was done for a mild endocervicitis in a patient who stated that she had no leukorrhea, with the hope that it would have a beneficial effect on the intermenstrual pain. The second case reported below is on in which both tubes had been removed at a previous operation with an operative verification of an inflammatory process in the broad ligament following cauterization.

### *Case Reports*

Case 1—Mrs. G. S., a white married female was admitted to the hospital on March 30, 1936. On March 16 she had a coagulation of the cervix. She felt well until the evening of the 20th when she began to have pain in her left lower abdomen which was dull and aching. She felt feverish and had some pain in the left lower back. This continued for one day and then gradually subsided, the temperature falling and the general feeling of well-being improving. On March 29, she began to have severe cramping pains in the lower midline, like menstrual cramps, intermittent and more or less rhythmic. These continued and she had severe backache over the left sacroiliac joint. Her whole lower abdomen felt sore and she also had pains just under the tip of the breast bone. The history is otherwise unessential. She had gained sixteen pounds of weight previous to the coagulation and had been in excellent health. There were no symptoms referable to any of the systems. Menstrual history was essentially normal except for intermenstrual pains. She had had no pregnancy. Her husband was living and in good health.

Physical examination on admission to the hospital was essentially normal except for a temperature of 100° and a mass in the left lower quadrant extending up about two-thirds of the distance from the symphysis to the umbilicus. The mass was rather tender and slightly fixed. The uterus was indistinguishable from the mass. Because of the history of rhythmic cramps similar to those at menstruation, a hematometra was thought present and a sound was passed gently into the uterine cavity and about two drams of old blood evacuated.

While the patient was anesthetized for the dilation and passage of a sound, a vaginal examination revealed a large mass in the left pelvis slightly fixed and indistinguishable from the uterus. A diagnosis was made of an inflammatory process in the left broad ligament and treatment was decided upon conservative lines, treating it as DeLee advises in a case of postpartum parametritis. The patient remained in the hospital running slight elevation of temperature. The mass failed to point in either the fornix or the cul-de-sac.

On April 7, twenty-one days after the cauterization, an incision above Poupart's ligament and an extraperitoneal drainage of the abscess was done. A large amount of pus was evacuated and several small pockets broken up with the finger. The patient's convalescence was normal and when last seen on August 1, '37, she was in excellent health and vaginal examination was negative.

Case 2—Mrs. R. A., white female was cauterized on April 12, 1937. Her backache was relieved by lying down. Five days later she was a little nauseated with

cramp-like pains in the lower right quadrant. She went to bed and stayed there. She had a large amount of gas on her stomach and great pain upon turning over in bed. These cramping abdominal pains continued until admission to the hospital on the 18th.

Past history: In July, 1933, she had been operated upon. An appendectomy was done and a uterine suspension. In August, 1935, she had a bilateral salpingectomy, left oophorectomy and a partial resection of the right ovary. Her menses had been very irregular since operation in August, 1935. On admission the patient vomited a small amount of fluid and bowels moved well with enema. There was a mass in right fornix continuous with the uterus, moderately fixed and tender. The impression at this time was that she had an abscess in the right broad ligament. With hot douches and rest the temperature gradually returned to normal and the patient's pain subsided. The mass was definitely smaller but there was an extension of inflammatory reaction down into the cul-de-sac. She was sent home to continue rest in bed. On May 9 the patient was readmitted to the hospital because of pain in the right side. An extension of the inflammatory process was felt in the cul-de-sac and attempted cul-de-sac drainage was unsuccessful. This was thought to be an ovarian cyst with inflammatory reaction around it. She was discharged but readmitted on June 17, when a laparotomy was performed. An ovarian cyst was removed and inflammatory thickening of the broad ligament noted at operation. The cyst was probably present before cauterization but the inflammatory reaction after cauterization and extension of the inflammatory process was definitely not due to any tubal infection as both tubes had been removed and there was no evidence of any impairment of the blood supply to the cyst which would lead one to suspect an inflammatory reaction from any condition in or around the cyst.

Besides the two cases above reported I have seen recently two cases of lower abdominal pain and temperature following cauterization of the cervix. The symptoms in both of these cases cleared with rest in bed and hot douches. In neither case was there a history of a criminal abortion, or salpingitis and in neither was there a retrodisplacement of the uterus.

### COMMENT

In discussing the subject with other doctors I was unable to find any major complications but nearly everyone had seen pain in the lower abdomen after cauterization. Several complications have been seen by other doctors in which the uterine cervix was cauterized during the fifth week postpartum. In both cases reported above there were definite extensions of an infection from the cervix. From a study of these cases and the cases reported in the literature I would list the following as contraindications for cauterization: septic abortion; acute and subacute gonorrheal salpingitis; postpartum patients under six weeks, possibly under eight weeks. I believe that, with existing knowledge, major complications following the use of the cautery will occur from time to time in spite of all precautions. There are



no reports of complications following a light surface cauterization, but this method of treatment is very much less effective than heavy cauterization as the cervical glands which are the seat of the disease are not destroyed. The unusual thing to me is the large number of cauterizations and the few complications.

Hiller quotes Curtis as follows: "Streptococcus infection of the tubes, as previously stated, is but part of a more widespread pelvic involvement. The complete picture may, however, closely resemble gonorrheal disease. A history of abortion, a persistent tendency to aching distress in the pelvis, a prolonged tendency to slight chills or low grade fever are suggestive. The tissues may yield bacteria for a long period of time: six months is fairly common. Recovery of streptococci after two years is not infrequent. In one instance they were obtained eighteen years after the initial infection." This statement emphasizes the most definite contraindication to cauterization. The reason for this statement is that the only deaths reported have occurred in this type of case. To have a patient in reasonably good health die following a cervical cauterization is indeed unfortunate and embarrassing and possibly deaths from cauterization could be prevented by obtaining a history of a criminal abortion and refraining from a cauterization. I do not feel that the presence of gonococci in a cervical smear should constitute a contraindication but rather an indication for cauterization providing there is no evidence of an acute or subacute inflammatory process in the tubes.

In conclusion, I hope that this report will stimulate more reports and possibly bring to light further knowledge on cervical cauterization and its complications.

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#### APPENDICITIS

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Today appendicitis is both the best and the poorest treated surgical disease of our daily practice. During the past five years approximately eleven hundred articles have appeared in the medical literature upon this subject. I shall not attempt to review these voluminous data, but it will be my purpose to indicate briefly the accepted views concerning the proper management of appendicitis in the light of these contributions. The incidence of appendicitis has steadily increased during the past twenty years throughout the civilized world. Two factors are chiefly responsible for this: increasing accuracy in the early clinical recognition of appendicitis and an ever-increasing, more highly artificial, so-called civilized method of living.

Accompanying this increase in incidence is a steadily increasing death rate following the surgical treatment of this disease. This increase in postoperative mortality has led to the erroneous hypothesis that this condition can be more successfully treated by the medical practitioner and that he in turn can more safely decide when surgical consultation should be requested. No physician, no matter how skilled he may be, can prognosticate in every instance as to the exact stage of the disease process present in the appendix at any given moment. Appendicitis is always a surgical problem from the instant its presence is suspected by the physician. Then is the time to request surgical consultation, not some six to eighteen hours later. In the case of suspected appendicitis in children, pediatric consultation should be immediately requested, if available.

The promiscuous self-catharsis practiced at home by the laity in an effort to self-treat the so-called case of "indigestion" has filled more graves than all the wars in which this nation has been engaged. Druggists should never supply, nor advise the use of cathartics to persons applying to them as a remedy for an upset stomach. These individuals should be urged by the pharmacist to consult immedi-

ately their own doctor and let him decide whether a laxative is indicated.

Another cause for the increasing death rate in appendicitis is the false impression held by many practitioners that anyone can safely perform an appendectomy. The occasional operator should not attempt to perform an appendectomy unless he is fully able to cope with any surgical condition that he may encounter in the abdominal cavity. The diagnosis of appendicitis carries with it the obligation of immediate surgery regardless of the time of day or the presence of important social events. Large series of cases have shown that delay of more than twenty-four hours after the initial onset of signs and symptoms increases the mortality rate six hundred to eight hundred per cent.<sup>1</sup>

Acute appendicitis today appears to be no less a problem than it was forty years ago. It is amazing, but none the less true, that its surgical treatment entails a mortality which, according to our most reliable sources, actually exceeds the figure which was claimed for its medical management forty years ago. It is natural that the morbidity of the disease should increase, paralleling the increase in the country's population, but it is also a fact that the mortality has been steadily increasing. Census bureau figures prove that the mortality rate from appendicitis has increased progressively during the past thirty years, and that only during the recent few years has it shown a slight tendency to recede. A grim touch of irony is contained in the fact that while such scourges as diphtheria, smallpox and tuberculosis have shown a truly remarkable response to public health control, appendicitis, which in a great many sections apparently has not attained the importance of a public health problem, has continued steadily on its way, and now exacts a toll of between twenty thousand and twenty-five thousand lives annually in the United States.<sup>2</sup> When we add to this requiem the tale of the million and more people, who are disabled through its ravages for varying periods of time annually, we gain a clearer concept concerning the magnitude of the economic importance of appendicitis today.

The Metropolitan Life Insurance Company has recently reported an increased death rate

among white males insured, of twenty per cent within nineteen years, and fourteen per cent for the same period among white females.

In determining the proper treatment to be used, age is the most important factor. Those past the age of forty years have been found to be ten times more liable to die following the same treatment as that used on younger patients. Children under ten years of age will withstand surgical therapy better and make a more prompt recovery than the young adult.<sup>1</sup> Seventy-five per cent of cases of appendicitis occur before the age of thirty years. The older the individual, usually the more atypical are the signs and symptoms and the more prompt will be gangrene, perforation, and the onset of generalized peritonitis.

Sex variation is of interest. More cases occur in males. However, females withstand the ravages and complications of appendicitis better and a greater percentage recover.

The treatment of cases of acute perforated appendicitis taxes to the utmost the skill and sound judgment of the surgeon. This group has always carried the highest surgical mortality of all types of appendicitis, largely because of the onset of generalized peritonitis due either to the failure of the abdominal contents to wall off a perforated appendix successfully or to ill-advised meddlesome surgery at an improper stage in the disease process. Formerly this type of appendicitis possessed a death rate of about 40 per cent. With skillful handling, this mortality should be reduced to less than 10 per cent. In this type, the muscle-splitting incision is the approach *par excellence* and an effort should be made to approach the cecum by a laterally placed incision in the right lower quadrant, so as to reach the head of the cecum extraperitoneally and to avoid exposing either the small bowel or to break up adhesions already formed which have partially walled off this area from the general peritoneal cavity. If the appendix can be removed with ease and without breaking down protective adhesions of abscessed walls, it may be done; otherwise, only simple but thorough drainage is indicated. These patients may return two or three months after their dismissal from the hospital for a subsequent appendectomy which then carries only

little more operative risk than the interval case. In instances of generalized diffused peritonitis, drainage should involve the ileocecal area, the right iliac fossa, along the right colic gutter, and the pelvic cavity.

The closure of an infected muscle-splitting incision should entail only the tight closure of the peritoneum about the drains; while the various muscle-layers are not resutured and only several retention sutures are placed through the skin and into the external oblique aponeurosis to obliterate dead spaces in the wound. The skin edges may be loosely approximated by either interrupted skin sutures or by a few skin clips. Additional suturing of the layers of the incision will lead only to their extensive necrosis and sloughing. Only soft rubber dam tubular Penrose drains without gauze wicks should be employed for the purposes of drainage. Even these soft, pliable drains in the presence of extensive wound infections may occasionally erode into neighboring blood vessels. In infected incisions of this character, early adequate drainage must be assured so that pocketing does not occur. The best results are obtained by leaving these wounds wide open and allowing them to heal from the bottom outwards.

In acute appendicitis, spinal anesthesia still remains the anesthetic of choice as it prevents excessive straining during anesthesia and thus minimizes the spread of peritonitis.<sup>1</sup> In children and in the aged, general anesthesia is still indicated.

Appendicitis is considered as a result of the sequence of obstruction, distention, circulatory stasis and infection. Obstruction is recognized as a reason but this prompts an inquiry as to the cause of the obstruction. Obstruction may be due to foreign body; mucus plug, edema or neoplasm, stricture; stasis, angulation, deformity; functional derangement; spasm. Probably variations in embryologic development will cause an autonomic imbalance causing overparasymphathetic or underparasymphathetic innervation of the ileocecal region.<sup>2</sup>

Much has been written concerning the fallacy of making a diagnosis of chronic appendicitis. Some authors deny the existence of such a clinical entity and maintain that really

all that one sees represents the end products of a healed acute appendicitis. There is now considerable clinical evidence to show that in the carefully studied case, in which all other conditions that may simulate appendicitis have been ruled out, appendices when removed have resulted in a high percentage of clinical cures. Pathologically, it seems futile to argue that changes similar to those commonly described for chronic appendicitis are in reality of no consequence, but that similar histological pictures presented elsewhere in the gastrointestinal tract and in the human body are pathognomonic of undoubted chronic inflammation.

The diagnosis of chronic disease of the digestive organs is often extremely difficult, despite modern diagnostic methods, and this is particularly true of chronic appendicitis, even the very existence of which is still doubted by some authors. From time to time many important clinicians, including Rolleston, Brown and Balfour, have emphasized the clinical importance of chronic appendicitis.

It is admitted that a wrong diagnosis of chronic appendicitis is occasionally made in a neuropathic individual. Mistakes of this nature are almost inevitable in all conditions and, of course, this small percentage of errors must be avoided if possible. By no means, however, should the majority be sacrificed in the interest of the small minority. In the words of the wise internist: "We must train ourselves to study the effects of disease, not in the grave but in the cradle."

Appendicular disease can simulate almost any disease in the human body, such as angina pectoris, cardiospasm, Addison's disease, peptic ulcer, gall bladder disease, etc.

I will give a few case histories taken from the Beth Israel Hospital to illustrate my point.

#### CASE REPORTS

Four patients were operated upon for severe hemorrhage from the stomach. The surgeon found the stomach and duodenum to be normal in each case, but in all there was a diseased appendix.

In another patient, a woman thirty-four years old, the mother of three children, the symptoms simulated Addison's disease. She consulted us because of extreme asthenia and persistent vomiting. Her blood pressure was 60/40, her skin was dark and there was discoloration of the mucous membrane of her mouth. She had lost a great deal of weight. The impression was that we were dealing with a case of Addison's disease, but in view of a history of two attacks of appendicitis a few



years before and the objective findings of tenderness in the right lower abdomen, she was advised to have her appendix removed and welcomed the suggestion. At operation, a diseased appendix was found and in the many years that have elapsed since its removal she has recovered her health and none of her symptoms have recurred. This case illustrates the endocrine disturbances that occasionally occur in patients with chronic appendicitis who may be considered to belong to the toxic group of appendices.

In 1924 a patient, subject to periodic attacks of pressure in the chest and hoarseness almost to the extent of complete aphonia, was referred to the Beth Israel Hospital. Physical examination including x-ray, studies of the chest and abdomen were all negative with the exception of some tenderness over the appendix region. A diseased appendix was removed from this patient after which she completely recovered from all her symptoms.

In May of this year a woman, aged 47, came to me complaining of pains in the epigastrium, right lower quadrant and right costovertebral angle. She gave a history of kidney trouble and stated that seven years previously she had been advised to have her right kidney removed. Because her son was killed in an automobile accident at that time she did not undergo the operation. She had been a semi-invalid for the past several years.

I advised a complete x-ray examination. The gastrointestinal series, cholecystogram and pyelograms were negative. An exploratory laparotomy was performed after she had had two transfusions. The only pathology found was a diseased appendix with adhesions to the cecum. This patient made an uneventful recovery, has been practically symptom-free since the operation, and able to carry out her normal household duties.

In closing this paper I would like to discuss the two types of incisions used in appendectomies, as I am a strong believer in the McBurney or muscle-splitting incision. Reid recently reported a decrease in mortality of fifty and three-tenths per cent in acute appendicitis when the operative incision was changed from a rectus to a McBurney.<sup>4</sup> Likewise, Pattison in reporting a comparative series of cases of acute appendicitis showed the mortality in similar cases with the rectus incision to be six and four-tenths per cent while with the McBurney incision it was reduced to six-tenths per cent. The arguments in favor of the McBurney incision may be cited as follows:

1. It gives direct approach with minimal trauma and contamination of the general peritoneal cavity.
2. Abdominal drainage through this incision is the shortest and most direct.
3. Statistics show fewer postoperative herniae following drained suppurative McBurney wounds than with any other kind of infected laparotomy incisions.
4. Secondary operations for intestinal obstructions, etc., if necessary, are facilitated by

the suppurating wound being in the right lower quadrant and away from the newly contemplated laparotomy wound.

5. Patients become ambulatory sooner. Numerous authors report differences of from three to five days.

6. A general exploratory incision is seldom needed for such limited and localized pathology.

Arguments against the McBurney incision are chiefly those associated with limited exposure. The argument in favor of the right rectus incision is principally that of adequate exposure. Arguments against the right rectus incision may be listed as follows:

1. Danger of disturbing the localized abscess contaminating the general peritoneal cavity.
2. Danger of evisceration with dissolution of the wound following infection.
3. Possibility of extensive adhesions with greater tendency to obstructions when drains cross the abdominal cavity to a rectus incision.

Recent reported opinion favors no drains in acute unruptured appendicitis, even in the presence of turbid intraperitoneal fluid which, for the most part, is only a protective exudate. An exception to this rule would be the presence of gross necrotic tissue in the region of the removed appendix.

So in a general way I leave this thought with you,

"'Tis better to use the knife too soon

And find our diagnosis wrong,

Than to hear the old familiar tune,

He's gone to join the heavenly throng.

"There are a thousand ways, more or less,

To treat this treacherous little waif,

But after all, we must confess,

The knife alone, in time, is safe."

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(Address all communications to Box 1018, Jacksonville)



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## IMPORTANT NOTICE REGARDING HOSPITAL INSURANCE PLAN

The Executive Committee of the State Medical Association wishes the members of the Association to know that it has not approved any plan of organization for hospital insurance in Florida.

A letter dated November 8, 1938, signed by W. E. Thomas, one of the managers of the Hospitalization Department of the Suwannee Life Insurance Company, together with a proposed state-wide hospitalization plan, dated November 3, 1938, was mailed to members of organized medicine in Florida. The proposed plan confines the sale of stock to members of organized medicine. This would mean a commercial organization restricted to members of the Florida Medical Association whose service would not be under the jurisdiction or control of the State Medical Association. It would simply be an independent hospitalization service, controlled by volunteer members of organized medicine.

The plan as outlined in the "proposal" has not been approved or disapproved by the Executive Committee of the Association. After an investigation of the plan, the members of the Association will be informed as to the

Committee's opinion of its advisability from a commercial and professional aspect.

## STUDY OF MEDICAL CARE

Officers of county medical societies are urged to complete and send in all forms concerning the Study of Need and Supply of Medical Care, supervised by the Bureau of Medical Economics of the American Medical Association. The collection of all material in connection with this study is to be through the county medical societies of the nation. In order to have reliable information, the officers of the A. M. A. are anxious to receive information on definite findings from the county medical societies. Firsthand information from the doctors themselves will form the basis for statistical tabulation that should prove very valuable to the medical profession. Information given out through unofficial surveys is often misleading. It is, therefore, our duty as medical men to cooperate with the A. M. A. officials in their endeavor to study the need and supply of medical care, as pictured through the material received directly from the doctors themselves.

Forms and blanks have been sent to the county medical society secretaries in Florida, through the State Association's office. As this issue of the Journal goes to press, however, very few county societies have forwarded completed questionnaires. Your cooperation is solicited and urged.

## APPLICATIONS FOR SCIENTIFIC PAPERS

### NEXT ANNUAL MEETING

Members of the Association desiring to present papers at the Sixty-sixth Annual Meeting of the Florida Medical Association, which will be held at Daytona Beach, May 1, 2, and 3, 1939, are urged to forward their applications promptly. A synopsis of the paper, not to exceed fifty words, must accompany each application. Applications will be considered by the Committee on Scientific Work at the Pre-Convention meeting. All applications, therefore, must be in the hands of this committee prior to the Pre-Convention meeting. Mail your application to Dr. Walter C. Jones, chairman of the Committee on Scientific Work, Box 1018, Jacksonville.



## SCIENTIFIC EXHIBITS

This year scientific exhibits at the Association's annual meeting at Daytona Beach, May 1, 2, and 3, 1939, will be under the supervision and direction of the Association's Committee on Scientific Work. Members of the Association desiring to enter a scientific exhibit are urged to file their applications promptly. Describe your exhibit, specifying the square feet necessary and if wall space is desired. Space is at a premium and it is, therefore, important for your committee to have a definite statement as to the linear feet of wall space, as well as the square feet of floor space. All applications for scientific exhibits must be filed on uniform application blanks. Members of the Association interested are urged to write to Box 1018, Jacksonville, for application blanks. Your applications must be filed not later than December 31, 1938.

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## INVITATIONS, 1940 ANNUAL MEETING

Invitations for the 1940 Annual Meeting of the Florida Medical Association must be presented to the Executive Committee prior to or at the Pre-Convention Meeting, according to Chapter 7, Section 6 of the By-Laws.

Officers of county societies are urged to note the provision of this By-law and any society desiring to invite the 1940 Annual Meeting should file its application promptly. Invitations should be addressed to P. O. Box 1018, Jacksonville.

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## GRAND JURY INVESTIGATES ORGANIZED MEDICINE

On October 17 the special grand jury called in the District of Columbia to investigate organized medicine began its study. The attorneys representing the government include John Henry Lewin, a special assistant selected by the Department of Justice, former city solicitor in Baltimore and later the people's counsel to the Maryland Public Service Commission. He is a graduate of Johns Hopkins University and the Harvard Law School. In 1933 he became a member of the trial section of the A. A. A. legal division and in 1937

conducted the government's antitrust case in Madison, Wis., against the oil companies. Mr. Lewin is 40 years old and was for a while editor of the Harvard Law Review.

His principal assistant in the case is Allan Hart of Portland, Ore., who first came to the attention of Mr. Thurman Arnold at Yale. In 1926 Mr. Hart was appointed assistant United States District Attorney in Portland and he was taken from that position to assist Mr. Arnold in Washington.

In addition to these two attorneys, the Department of Justice is utilizing Grant W. Kelleher and Douglas B. Maggs, the latter called to the Department of Justice from Duke University specifically for this case.

The first of the witnesses to be called before the grand jury was Dr. Hugh Cabot. It is understood that the attorneys for the Department of Justice wished to keep secret, if possible, the names of witnesses to be called before the grand jury. In interviews with reporters after testifying, Dr. Cabot declined to discuss his testimony but, according to the press, while waiting to be summoned to the grand jury room he discussed his theories of medical service. He deprecated proposals to subsidize treatment in the hands of private practitioners for people unable to afford regular medical charges. Apparently Dr. Cabot indicated his conviction that medicine is not a "trade." He is also reported to have said "Whether a criminal prosecution is the right approach to the problem I cannot say; I am not expert on criminal prosecutions. However, I can say that other methods which have been employed have not been successful; the problem remains unsolved." (*See A. M. A. article for comment on three other witnesses*).

As we go to press there are indications that additional witnesses will be Theodore Wiprud, executive secretary of the Medical Association of the District of Columbia, and William C. Woodward, director of the Bureau of Legal Medicine and Medical Legislation of the American Medical Association.

—*Jour. A. M. A., October 29, 1938.*

## MEDICAL DISTRICT MEETING—F

Fort Lauderdale—October 13

The second annual meeting of the Southeast Medical District was held at Fort Lauderdale, Thursday afternoon at 3 o'clock, with headquarters at the Hotel Champ Carr. There was a total registration of 69. Of this number, 57 were Association members (from this district, 54); 7 were visitors; and 5 were ladies.

Dr. Lloyd J. Netto asked all present who had not registered to do so. A number of late arrivals had not registered. Miss Dorothy Robinson, daughter of the Association's president-elect, assisted on the registration desk and her services were very much appreciated.

The Champ Carr Hotel was a very convenient place to hold the district meeting. The manager and his associates extended every courtesy. The local committee on arrangements looked after the entertainment of the ladies but some of the plans could not be carried out, owing to the wet weather. The dinner was held in the Endor and Farrell Coral Club and was well attended. The bill of fare included Florida lobster and many other savory dishes. The occasion was informal and everyone enjoyed the good fellowship.

At 3:25 p. m. Dr. Lloyd J. Netto, president-elect, called the general session to order. Dr. Harrison A. Walker, president of the district, was absent because of the death of his mother. The address of welcome was delivered by Dr. A. B. Connor, president of the Broward County Medical Society. In addition to welcoming the members and guests, Doctor Connor emphasized the importance of the district meetings. Dr. W. Henry Spiers, president of the State Association, gave a short address, outlining the Association's program for the year. Dr. F. K. Herpel, past senior councilor of the district, reported for Doctor Walker. From his experience last year, Doctor Herpel presented the work of the Council in a very acceptable manner.

The next speaker was Dr. Meredith Mallory, the Association's representative to the A.M.A. House of Delegates. Doctor Mallory reported on the special meeting of the House of Delegates, held in Chicago last September. Dr.

Leigh F. Robinson, president-elect of the State Association, was recognized and made a few remarks but mentioned that his official duties would not be in force until next year. Dr. Gilbert S. Osincup, Chairman of the Association's Executive Committee, made a fine talk, emphasizing the importance of county societies adopting legal constitutions and by-laws and the importance of a fee schedule. Doctor Osincup also brought to the group some firsthand information concerning the special, called meeting of the A. M. A. House of Delegates in Chicago and his stopover visit in Washington, D. C., en route. Dr. Homer L. Pearson, past president, 1934, was recognized. Dr. Walter C. Jones, Chairman of the Scientific Work Committee, was recognized and emphasized the importance of early applications by doctors who desire to read papers before the next State Association meeting. Dr. Arthur H. Weiland, Chairman of the Committee as Representatives to Industrial Council, gave a short talk on the questions of interest pertaining to his committee. Dr. Roy J. Holmes, Chairman of the Committee on Public Relations, was heard briefly.

Doctor Netto, on behalf of the Palm Beach County Medical Society, invited the next medical district meeting to West Palm Beach. The invitation was unanimously accepted.

After a short recess, Doctor Netto at 4:55 called the scientific session to order. The first paper was read by Dr. E. W. Cullipher of Miami on "Common Foot Ailments." The next paper was by Dr. Elliott M. Hendricks of Fort Lauderdale on "Present Status of Cancer Therapy." The last paper was presented by Dr. Efton J. Thomas of Miami on "Jellyfish and Portuguese Man-of-War Stings." These papers were well presented and stimulated discussions which indicated the interest and the appreciation of those present.

This was the second annual meeting in this district and the enthusiasm for such occasions was quite evident.

## REGISTRATION

Netto, Lloyd J., *President-Elect*... West Palm Beach  
Thompson, Stewart, *Managing Director*... Jacksonville

*Association Members*

Anderson, James L. .... Miami  
Blount, Robert E. .... Ft. Lauderdale

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Connor, A. B.....	Ft. Lauderdale
Coplan, M. M.....	Miami
Cullipher, E. W.....	Miami
Dame, Leland H.....	West Palm Beach
Darrow, Anna A.....	Ft. Lauderdale
Derrick, C. J.....	West Palm Beach
Elgin, L. W.....	Miami Beach
Elliston, L. B.....	Ft. Lauderdale
Elliston, R. L.....	Ft. Lauderdale
Glenn, Francis W.....	Miami
Hendricks, Elliott M.....	Ft. Lauderdale
Herpel, F. K.....	West Palm Beach
Holmes, Roy J.....	Miami
Johnston, J. A.....	Ft. Lauderdale
Jones, Allan.....	Miami Beach
Jones, Walter C.....	Miami
Lamar, Carlos P.....	Miami
Leavitt, H. A.....	Miami
Levin, Alfred G.....	Miami
Lucinian, J. H.....	Miami
McClellan, George S.....	Pompano
McKibben, William W.....	Miami
McMurray, J. W.....	Ft. Lauderdale
Mallory, Meredith.....	Orlando
Mayhew, Royal H.....	Ft. Lauderdale
Melvin, P. D.....	Miami
Mendel, James H.....	Miami
Norman, Estella G.....	Miami Springs
Nowling, J. C.....	West Palm Beach
Osincup, G. S.....	Orlando
Owens, W. Duncan.....	Miami Beach
Pallister, William T. H.....	Miami
Payton, F. J.....	Miami Beach
Pearson, Colquitt.....	Miami
Pearson, Homer L.....	Miami
Peavy, H. J.....	Ft. Lauderdale
Perdue, Jean Jones.....	Miami Beach
Perdue, J. Randolph.....	Miami
Pierce, F. D.....	Ft. Lauderdale
Raap, G.....	Miami
Robinson, Leigh F.....	Ft. Lauderdale
Sams, Wiley M.....	Miami
Sandberg, T. D.....	Coral Gables
Shackelford, C. W.....	West Palm Beach
Shell, Paul G.....	Dania
Smith, Donald W.....	Miami
Sory, C. H.....	Ft. Lauderdale
Spiers, W. H.....	Orlando
Stewart, Joseph S.....	Miami
Stovall, R. H.....	Ft. Lauderdale
Thomas, E. J.....	Miami Beach
Walters, Arthur.....	Miami Beach
Weiland, Arthur H.....	Coral Gables
Willis, Hilliard W.....	Coral Gables

#### *Visitors*

Dowlen, L. W.....	Miami
Horwitz, Abraham.....	Ft. Lauderdale
Howard, R. E.....	Ft. Lauderdale
Shapira, Albert A.....	Ft. Lauderdale
Ullian, Louis.....	Ft. Lauderdale
Whitmar, Kenneth.....	Miami

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Leavitt, Mrs. H. A.....	Miami
McKibben, Miss Darthea.....	Coral Gables
Robinson, Mrs. Leigh F.....	Ft. Lauderdale
Walters, Mrs. Arthur.....	Miami Beach

## MEDICAL DISTRICT MEETING—B

Gainesville, October 27

The second annual meeting of the North Central Medical District was held at Gainesville, Thursday afternoon at 3 o'clock, with headquarters at the Hotel Thomas. There was a total registration of 48. Of this number, 47 were Association members (from this district, 37) and 1 was a visitor.

The attendance was approximately the same as at last year's annual meeting in this district.

The Hotel Thomas was a delightful place to meet and every courtesy was offered by the manager and his associates. Dr. J. L. Summerlin, chairman of the local Committee on Arrangements, assisted by Dr. E. H. Andrews, looked after the facilities for the meeting, entertainment, dinner, etc. The evening dinner was served in the Hotel Thomas dining room and was a very pleasant occasion. Tables were arranged in horseshoe formation in a very large room and the food was excellent. Quite a number of ladies who were not in evidence during the meeting proper, attended the banquet and added to the pleasure of the occasion. Dr. T. A. Snow, president of the local medical society, was in charge of the dinner.

At 3:30 p. m. Dr. R. B. Harkness, senior councilor and president of the North Central Medical District, called the meeting to order. Dr. T. A. Snow, president of the Alachua County Medical Society, gave the address of welcome. Dr. W. Henry Spiers, president of the State Association, gave a very interesting talk on Association affairs. Dr. Shaler Richardson, secretary-treasurer of the Association and editor of the Journal, outlined briefly the work in the home office, publication of the Journal, etc. In concluding his talk, Doctor Richardson brought some firsthand information from the special, called meeting of the A. M. A. House of Delegates, which was held during September in Chicago. Dr. Harrison A. Walker, chairman of the Council, outlined the activities in which the Council is now engaged and emphasized the growing interest in the medical district meetings of the Association. Doctor Gilbert Osincup, chairman of the Association's Executive Committee, stressed the importance of county medical societies having legal constitutions and by-laws adopted and



the filing of a copy in the office of the State Association. Doctor Osincup also brought some firsthand information from the Chicago meeting of the A. M. A. House of Delegates. The doctors present seemed to appreciate the oral reports from the Chicago meeting. Dr. Luther W. Holloway, chairman of the State Association's Committee on Child Health, was recognized and talked briefly. Dr. W. McL. Shaw, councilor for the fifth district and immediate past chairman of the Council, was present and was asked to make a few remarks. Dr. Henry C. Dozier, past president, 1929, was then recognized and discussed several Association activities.

Doctor Harkness then called for invitations for next year's meeting place and Dr. R. D. Ferguson, on behalf of the Marion County Medical Society, extended a cordial invitation to meet next year in Ocala. Doctor Harkness mentioned that the doctors in Lake City would be very glad to have the meeting but, since it was in the extreme northern part of the district which is so large, he agreed with Doctor Ferguson that it would be more beneficial to the district to have the meeting as nearly central as possible. By unanimous vote, Ocala was selected as the meeting place for 1939.

After a short recess, Dr. James L. Strange, junior councilor and president-elect of District B, called the scientific session to order. The first paper was presented by Dr. S. C. Harvard of Brooksville on "Cauterization of the Cervix." Dr. Henry C. Dozier of Ocala led the discussion. The second paper was by Dr. T. H. Bates of Lake City on "Intestinal Parasites Causing Surgical Conditions." Dr. W. C. Thomas of Gainesville led the discussion. The third paper was by Dr. W. J. Baker of Foley on "Undulant Fever." Dr. R. D. Ferguson of Ocala led the discussion. The last paper was by Dr. E. L. Scott of Ocala on "The Responsibility of the General Practitioner to the Crippled Child." Dr. R. C. Cumming of Ocala led the discussion on this paper which was illustrated with slides.

All the papers were well presented and an unusual number of doctors present entered into the discussion. The interest was so keen in this scientific session that the time was extended forty-five minutes.

Following the scientific session, Dr. Har-

rison A. Walker called the Councilors present together for a short meeting.

#### REGISTRATION

Harkness, R. B., *President* ..... Lake City  
Strange, J. L., *President-Elect* ..... McIntosh  
Thompson, Stewart, *Managing Director*... Jacksonville

#### Association Members

Ahmann, Chester F. .... Gainesville  
Andrews, Edwin H. .... Gainesville  
Baker, W. J. .... Foley  
Bates, T. H. .... Lake City  
Britt, Reddin. .... St. Augustine  
Chalker, J. L. .... Ocala  
Cobb, A. T. .... Gainesville  
Cone, D. N. .... White Springs  
Creekmore, G. R. .... Brooksville  
Cumming, R. C. .... Ocala  
Dailey, I. A. .... Micanopy  
Dell, J. M., Jr. .... Gainesville  
Dozier, H. C. .... Ocala  
Ferguson, R. D. .... Ocala  
Floyd, G. M. .... Hawthorne  
Harrell, H. L. .... Dade City  
Harvard, S. C. .... Brooksville  
Holloway, Luther W. .... Jacksonville  
Limbaugh, Louie .... Jacksonville  
Lytle, Carl S. .... Dunnellon  
McCreary, A. B. .... Jacksonville  
Maines, John E., Sr. .... Lake Butler  
Maines, John E., Jr. .... Gainesville  
Merchant, Harry M. .... Gainesville  
Mimms, C. W. .... Ocala  
Moore, J. N. .... Ocala  
Murphree, W. E. .... Raiford  
Osincup, Gilbert S. .... Orlando  
Preston, H. F. .... Melrose  
Richardson, Shaler .... Jacksonville  
Russell, R. E. .... Ocala  
Shaw, W. McL. .... Jacksonville  
Smith, D. T. .... Gainesville  
Snow, T. A. .... Gainesville  
Spiers, W. Henry .... Orlando  
Stutts, B. S. .... Dunnellon  
Summerlin, J. L. .... Gainesville  
Thomas, John H. .... Gainesville  
Thomas, W. C. .... Gainesville  
Tillman, George C. .... Gainesville  
Walker, Harrison A. .... Miami Beach  
Walters, W. H. .... Lacoochee  
Watt, Harry F. .... Ocala  
White, Herbert E. .... St. Augustine  
Young, W. C. .... Chiefland

#### STATE NEWS ITEMS

Drs. John S. Helms, Jr., and James T. Cowart of Tampa returned recently from an automobile tour of the west where they visited several clinics and hospitals.

\* \* \*

Dr. W. C. McConnell of St. Petersburg was elected vice-president of the Southern Psychiatric Association at the meeting held in Atlanta, October 11. The Association is affiliated with the American Psychiatric Association and includes thirteen southern states and the District of Columbia.

The dates of the 1939 annual meeting of the Florida Medical Association will be May 1, 2, and 3. The officers of the Volusia County Medical Society directed a communication to the Executive Committee of the State Association, requesting the approval of the above dates, which have been confirmed by the management of the Princess Issena Hotel, Daytona Beach. The closing time of this hotel has been extended to allow the latest possible date to be set.

\* \* \*

At the Eleventh Annual Meeting of the Florida East Coast Medical Association, held at Rockledge, October 28 and 29, the following officers were elected: Dr. Frederick J. Waas, Jacksonville, president; Dr. Thomas C. Kenaston, Cocoa, vice-president; Dr. M. Jay Flipse, Miami, vice-president; and Dr. A. J. Logie, Jacksonville, secretary-treasurer. Jacksonville was selected as the place of the 1939 meeting.

\* \* \*

Dr. A. B. McCreary of Jacksonville, Director of the Bureau of District and County Health Work of the State Board of Health, spent some time in Tavares recently, where he instituted the new Lake County Health Unit which is headed by Dr. Terry Bird of Tavares.

\* \* \*

Dr. Lauren Sompayrac of Jacksonville has returned from a three months' course of study in the New York Skin and Cancer Unit of the New York Postgraduate Medical School and Hospital.

\* \* \*

Dr. and Mrs. Harrison G. Palmer of St. Petersburg have returned from a vacation spent in North Carolina and Michigan. While in Detroit, Doctor Palmer spent about a month attending clinics. He also attended the meeting of the Michigan State Medical Association held in that city.

\* \* \*

Dr. James S. Grable of Tampa recently returned from an extensive tour of the western and northwestern states.

\* \* \*

Dr. and Mrs. Francis T. Holland of Tallahassee announce the birth of a son, Charles Jackson, September 26, 1938.

At the meeting of the Gulf Coast Clinical Society, held in Pensacola, October 6 and 7, Dr. J. H. Dodson of Mobile was elected president to succeed Dr. Herbert L. Bryans of Pensacola. Dr. J. S. Tuberville of Century was elected vice-president. Dr. Henry Spiers of Orlando, president of the Florida Medical Association, was a guest speaker. Dr. W. C. Payne of Pensacola was chairman of the entertainment committee.

\* \* \*

Dr. John A. Simmons of Arcadia has returned from an extended motor trip through the southwest, having visited Birmingham; Memphis; his old home, Little Rock; Hot Springs; Baton Rouge and New Orleans. Mrs. Simmons accompanied him.

\* \* \*

Dr. Francis W. Glenn, who specializes in bone and joint surgery, and Dr. G. J. Walsh, who does general surgery, have become associated with the Tunlin Clinic, 800 N. E. Second Avenue, Miami.

\* \* \*

Dr. J. M. Bryant of Jacksonville spent the month of October in New York City where he completed a four-weeks' postgraduate course in advanced gynecology at the New York Postgraduate Medical School and Hospital.

\* \* \*

Dr. Edgar Watson of Lakeland returned recently from a trip to Europe. He spent three months in the Orthopedic Division of the Royal Infirmary at the University of Edinburgh, Scotland, and one month's study at Professor Böhler's Clinic in Vienna.

\* \* \*

Application blanks are now available for space in the Scientific Exhibit at the St. Louis Session of the American Medical Association, May 15-19, 1939. Attention is called to the fact that the meeting is a month earlier than usual, and applications close January 5, 1939. Blanks will be sent on request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

At the Clinical Congress of the American College of Surgeons, held in New York October 17-21, the following doctors from Florida received Fellowship: Charles J. Collins, Orlando; Horace A. Day, Orlando; John S. Helms, Jr., Tampa; John S. McEwan, Orlando; Cayetano Panettiere, Miami Beach; Lauchlin M. Rozier, W. Palm Beach; Ralph E. Russell, Ocala; Frank G. Slaughter, Jacksonville; Ferdinand A. Vogt, Miami; and Herman Watson, Lakeland.

Dr. Frederick J. Waas of Jacksonville was elected to the Board of Governors.

Other members of the Florida Medical Association who attended the Clinical Congress were: Edwin H. Andrews, Gainesville; Julius C. Davis, Quincy; M. P. DeBoe, Miami; S. F. Elder, Miami; C. D. Hoffman, Orlando; George D. Lilly, Miami; R. O. Lyell, Miami; Clarence W. Lynn, Orlando; Kenneth A. Morris, Jacksonville; Ralph D. Murphy, St. Petersburg; Harry A. Peyton, Jacksonville; George W. Richardson, Jacksonville; Leigh F. Robinson, Ft. Lauderdale; J. W. Snyder, Miami; Harrison A. Walker, Miami Beach; Edgar Watson, Lakeland; E. C. Watt, Jacksonville; J. Ralston Wells, Daytona Beach; Hugh West, DeLand; D. Ward White, Miami Beach; Herbert E. White, St. Augustine.

\* \* \*

The members of the Florida Medical Association who attended the American Public Health Association's annual meeting in Kansas City, Missouri, in October were Dr. W. A. McPhaul of Jacksonville, State Health Officer; Dr. N. A. Upchurch, Jacksonville City Health Officer; Dr. G. N. MacDonell, Miami City Health Officer; Dr. J. R. McEachern, Tampa City Health Officer; Dr. J. N. Patterson, of the State Board of Health, Jacksonville; and Dr. W. H. Pickett, of St. Petersburg, Director of the Pinellas County Health Unit. Doctor Pickett was a delegate from Florida.

\* \* \*

Dr. and Mrs. Thomas H. Lipscomb of Jacksonville announce the birth of a daughter, Susan Mary, on October 13 in St. Luke's Hospital.

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## BUTLER HALL SANCHEZ

Dr. B. H. Sanchez of Plant City died in a Tampa hospital on September 21, at the age of 51.

Doctor Sanchez was a native of Trenton, Florida. He first came to Plant City for the practice of medicine in 1912, remaining there until the World War in 1917, when he entered the medical corps of the U. S. Army. Following the close of the war, he spent two years practicing in Kentucky after which he returned to Plant City where he became permanently located.

For a number of years Doctor Sanchez had been secretary of the Midland Medical Society; he was a member of the Hillsborough County Medical Society, the Florida Medical Association and the American Medical Association. He was a member of St. Clement's Catholic Church.

Surviving are his widow, Mrs. Jeanette Eugenia Sampson Sanchez; two sons, Butler Hall, Jr., and Alex Stewart Sanchez of Plant City; and a daughter, Miss Eugenia Josephine Sanchez of Jacksonville.

---

## THOMAS BUTTERMORE ECHARD

Dr. T. B. Echard, retired physician and surgeon of St. Petersburg, died at his home on the morning of September 24, at the age of 60.

Doctor Echard was a graduate of the University of Pennsylvania and served his medical internship at West Penn Hospital, Pittsburgh. From 1901 until 1925 he conducted a private practice in Connellsville, Pa., also serving as surgeon for the Frick Coal Company, Pennsylvania Railroad Company, Western Maryland Railroad Company, and the West Penn Power Company.

He came to St. Petersburg in 1925 where he practiced until his retirement, two years ago, during which time he was an active member of the Mound Park and St. Anthony Hospital staffs. He was chief of staff of Mound Park Hospital in 1931 and vice-chief of St. Anthony's in 1932. He was surgeon



for the American Legion Crippled Children's Hospital during its early days.

Dr. Echard was an active member of the Pinellas County Medical Society and the Florida Medical Association until his retirement when he was made an honorary member of these organizations. He was a life member of the Masonic Lodge of Connellsville, a Knight Templar and a charter member of the Connellsville Kiwanis Club.

Surviving are his widow, Mrs. Olive C. Echard, and two sons, Thomas C. Echard of St. Petersburg, and William W. Echard, a student at the University of Virginia. Another son, Richard W. Echard, died while attending the University of Virginia in 1936.

## COMPONENT COUNTY SOCIETIES

### DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society met in regular session on November 1, at 8:30 p. m., in the Ingraham Building. The principal speaker of the evening was Dr. A. Buist Litterer, who presented "The Clinical Value of Quantitative Blood Studies in the Management of Syphilis, Including Fever Therapy." This paper was illustrated with lantern slides. Drs. Kenneth Phillips and Milton Coplan opened the discussion.

\* \* \*

### DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular monthly meeting in the library of the State Board of Health Building on the evening of November 1. The following papers comprised the scientific program:

"Diagnosis of Pain in the Hip in Children"—John F. Lovejoy. Discussion opened by Charles B. Mabry.

"Retinal Detachment"—Shaler Richardson.

"The Dysentery Problem in the Jacksonville Area"—James L. Borland. Discussion opened by E. B. Milam.

\* \* \*

### HILLSBOROUGH COUNTY MEDICAL SOCIETY

At a recent meeting, the following resolution was passed by the Hillsborough County Medical Society:

### BUTLER H. SANCHEZ

Be it resolved that the Hillsborough County Medical Society has suffered a loss long to be remembered and a friend revered. That this resolution be entered in the minutes of the Society and a copy be sent to the bereaved family and the Florida Medical Journal.

On September 21, 1938, the Hillsborough County Medical Society and Plant City, Florida, lost a friend and loyal brother physician in the passing of Butler Hall Sanchez after six weeks' illness. His enthusiasm and energy were boundless, his loyalty unquestioned, and his fidelity to organized medicine never faltered.

(Signed) J. W. Alsobrook,  
T. C. Maguire,  
Robert C. Black,  
Edgar Austin.

\* \* \*

### LEON-GADSDEN-LIBERTY-WAKULLA- JEFFERSON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held at Quincy on the afternoon of October 20. The scientific program consisted of the following three papers:

"When to Operate for Urinary Calculi,"  
Rudolph Bell, Thomasville, Ga.

"A Review of Syphilis at State Hospital,"  
J. C. Robertson, Chattahoochee.

"Menace of State Medicine," R. F. Godard,  
Quincy.

The following officers were elected to serve for 1939: president, W. W. Massey, Quincy; vice-president, F. T. Holland, Tallahassee; secretary-treasurer, B. A. Wilkinson, Tallahassee.

\* \* \*

### PALM BEACH COUNTY MEDICAL SOCIETY

THE PALM BEACH COUNTY MEDICAL SOCIETY HAS PAID 100% DUES FOR 1938, AND HAS BECOME THE SEVENTEENTH SOCIETY ON THE HONOR ROLL. THIS SOCIETY, WHICH HAS A MEMBERSHIP OF 58, IS OFFICERED BY: V. M. JOHNSON, PRESIDENT; GAYLORD LEWIS, VICE-PRESIDENT; J. R. SORY, SECRETARY; AND F. K. HERPEL, TREASURER. CONGRATULATIONS, PALM BEACH COUNTY MEDICAL SOCIETY!

PASCO-HERNANDO-CITRUS COUNTY MEDICAL  
SOCIETY

THE PASCO - HERNANDO - CITRUS COUNTY MEDICAL SOCIETY HAS REACHED THE TOP. THIS SOCIETY WITH A MEMBERSHIP OF 15 DRAWS ITS MEMBERS FROM 8 CITIES. TO HOLD THE INTEREST OF DOCTORS SO SCATTERED AND TO PLACE THE SOCIETY ON THE HONOR ROLL REQUIRES MORE EFFORT THAN USUAL ON THE PART OF ITS OFFICERS; ALSO A GREATER EXPENDITURE OF TIME AND MONEY ON THE PART OF EACH MEMBER. THIS SOCIETY IS, INDEED, TO BE CONGRATULATED ON ITS ACCOMPLISHMENT. THE FOLLOWING OFFICERS SERVED DURING 1938:

PRESIDENT—S. C. HARVARD;

FIRST VICE PRESIDENT—

W. H. WALTERS;

SECOND VICE PRESIDENT—

C. L. CARTER;

SEC'Y-TREAS—G. R. CREEKMORE.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

The Annual Meeting of the Pinellas County Medical Society was held at the Chatterbox, October 7. After refreshments and dinner, President Strickland called the assembly to order at 7:20 p. m.

The following applicants were voted into membership in the Society: W. H. Pickett and Fred Eugene Whaley.

The election of officers was held, which resulted as follows: President-elect, J. A. Herring; first vice-president, N. W. Gable, Jr.; second vice-president, C. B. Wright; secretary-treasurer, W. C. McConnell; censors, G. M. Lochner, H. W. Wade.

Dr. E. C. MacCordy was installed as president for the coming year.

The Pinellas County Medical Society recently adopted a uniform Fee Schedule for industrial cases. This schedule has been printed in a handy pocket-sized pamphlet for the convenience of Society members.



## EDUCATION

Physicians who teach correct bowel management to their patients will appreciate the value of the new "Habit Time" booklet as a means of impressing patients with the importance of bowel regularity.

"Habit Time," written for doctors' patients in a clear, interesting style, embraces a discussion on diet, exercise and bowel regularity, in addition to a simple explanation of the functions of digestion.

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At a recent meeting of the Pinellas County Medical Society, the following resolutions were adopted with regard to the deaths of two Honorary Members of the Society:

#### THOMAS B. ECHARD

WHEREAS, God in His infinite wisdom hath seen fit to remove from our midst one of our most beloved brothers, Dr. Thomas B. Echard, and,

WHEREAS, we, the members of the Pinellas County Medical Society feel deeply the loss of our beloved brother and friend; therefore be it

RESOLVED, that the Pinellas County Medical Society expresses its sorrow in the passing of Doctor Echard; that a copy of this resolution be sent to his family; that a copy be entered on the minutes of this Society; that the same be published in the Journal of the Florida Medical Association.

(Signed) FRANCIS H. LANGLEY.  
W. W. HARDEN.

#### GEORGE E. OSGOOD

WHEREAS, God in His infinite wisdom hath seen fit to remove from our midst one of our most beloved brothers, Dr. George E. Osgood, and,

WHEREAS, we, the members of the Pinellas County Medical Society feel deeply the loss of our beloved brother and friend, therefore be it

RESOLVED, that the Pinellas County Medical Society expresses its sorrow in the passing of Doctor Osgood; that a copy of this resolution be sent to his family; that a copy be entered on the minutes of this Society; that the same be published in the Journal of the Florida Medical Association.

(Signed) FRANCIS H. LANGLEY.  
W. W. HARDEN.

#### POLK COUNTY MEDICAL SOCIETY

The October meeting of the Polk County Medical Society was held at the Morrell Memorial Hospital on the evening of the 12th.

Dr. W. W. Shafer of Haines City, president of the Society, gave an interesting talk on the relationship between the medical profession, the bar and the courts. Dr. C. W. Pease of Bartow discussed the need for a tuberculosis x-ray clinic.

Following the scientific program, the members inspected the new x-ray equipment of the hospital, where a demonstration was given by Dr. John Jares, head of the hospital's x-ray department.

\* \* \*

#### PUTNAM COUNTY MEDICAL SOCIETY

Drs. E. W. Ford and J. E. Rose of Crescent City were hosts at a dinner meeting of the Putnam County Medical Society held at the New Gables Inn in Crescent City on October 11.

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SURGERY—General Courses One, Two, Three and Six Months; Two-weeks' Intensive Course in Surgical Technique with practice on Living Tissue; Clinical Courses; Special Courses. Courses start every Monday.

GYNECOLOGY—Two-weeks' Course starting February 27, 1939. Clinical and Personal Courses starting every week.

OBSTETRICS—Two-weeks' Intensive Course starting March 13, 1939. Informal Course starting every week.

FRACTURES AND TRAUMATIC SURGERY—Informal Course every week; Intensive Ten-day Course starting February 13, 1939.

OPHTHALMOLOGY—Two-weeks' Intensive Course starting April 24, 1939. Informal Course starting every week.

OTOLARYNGOLOGY—Two-weeks' Intensive Course starting April 10, 1939. Informal Course starting every week.

CYSTOSCOPY—Ten-day Practical Course rotary very two weeks.

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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Injuries to the Bones of the Elbow—WEILAND, ARTHUR H., Coral Gables, South. Surg. 7: 54-60 (Feb.), 1938.**

Fractures about the elbow joint may involve either the lower end of the humerus or the upper ends of the ulna or radius.

Fractures of the lower end of the humerus are for the most part treated alike, i. e., "adequate reduction under anesthesia and fixation in acute flexion." The author emphasizes the fact that reduction entails actual manipulation to secure approximation of fragments.

Post-reduction treatment is also of extreme importance. General active exercise is instituted on the tenth day and range of motion is gradually increased. Physiotherapy at this stage is of great value. Later, when union is firmer, gradually increased weight supporting by means of the well known pail of sand, is useful.

Cases of "T" fracture with excessive comminution require resection of the lower end of the humerus or sometimes of the whole joint where the radius and ulna are involved. The arm is then placed in a right angle splint and gentle traction forward and outward is instituted. The result is usually a fairly stable movable joint instead of the ankylosed elbow of those treated only by fixation.

Fracture of the coronoid process of the ulna rarely occurs without posterior dislocation. Reduction is easily obtained by placing the elbow in acute flexion.

Fracture of the olecranon in contradistinction to all other elbow fractures requires fixation in complete extension. Where inadequate approximation of surfaces is obtained, open reduction is resorted to and fragments are fastened with kangaroo tendon.

Fractures of the upper end of the radius where there is little displacement are best treated by fixation in acute flexion and complete supination. If there is much displacement, especially of the radial head, resection should be done without delay.



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ALBERT F. BRAWNER, M.D., *Resident Supt.*

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### Negative Results of Rhus Antigen Treatment of Experimental Ivy Poisoning—SOMPAYRAC, LAUREN McC., Jacksonville. *J. Med. Sciences* 195:361-362 (Mar.), 1938.

Of 23 student volunteers reacting to a tincture of leaves, bark and stem of Rhus toxicodendron, 9 were selected for treatment by means of injections of Rhus toxicodendron antigen prepared by one of the large drug houses. The remaining 14 were used as controls.

The author concluded that its use did not shorten the course of the dermatitis and had, if any, only slight effect on the intensity of the itching. In view of the expense and discomfort to the patient and the questionable effectiveness, its use is unwarranted.

#### ADVERTISERS' NOTES

##### AMERICAN OPTICAL CO.

33 per cent of the people of American Optical Company, largest and oldest manufacturer and distributor of optical products, have served the company 10 years or more, a study of its force revealed.

The report showed the following:

2,028 have served 10 years or more; 212 are veterans of 25 years or more; 11 have been with the company 50 years or more, and 1 is still employed after 60 years of service.

In addition, there are 6 retired and 10 deceased who served 50 years or more; and 1 retired and 3 deceased who served 60 years or more. There are 3 women now working who served 40 years or more, and 1 retired who served 50 years.

"We believe this a remarkable record," Royal Parkinson, Manager of Personnel, said in making public the study, "although it is dependent, in part, on the age of American Optical Company which was founded in 1833. Only an old and established firm could employ people for such lengthy terms of service.

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##### SQUIBB INSTITUTE FOR MEDICAL RESEARCH

Dr. George A. Harrop, formerly associate professor of medicine in Johns Hopkins University and associate physician of Johns Hopkins Hospital, has been appointed director of research in direct charge of the new Squibb Institute for medical research, at New Brunswick, N. J. Dr. Harrop will also head the Division of Experimental Medicine.

Dr. Harry B. van Dyke has been chosen head of the Division of Pharmacology. He comes to the Institute from Peiping Union Medical College in China, where he was professor and head of the department of pharmacology. He was also formerly a professor of pharmacology in the University of Chicago.

Associates in the Division of Pharmacology are Dr. Roy O. Greep, who has been an instructor in the biological division of Harvard University, and Dr. B. F. Chow, former associate professor in Peiping Union Medical College, and former member of the department of organic chemistry at Harvard University and at the Rockefeller Institute for Medical Research, New York City.

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Dr. Geoffrey W. Rake, former research associate in the Connaught Laboratories of Toronto University, heads the Division of Bacteriology and Virus Diseases. Dr. Rake has also been on the staff of the Rockefeller Institute. Associates in this Division are Dr. Arthur E. O. Menzel, previously instructor in biological chemistry in the Columbia University School of Medicine, and Dr. Morris F. Shaffer, formerly assistant in the department of immunology of the School of Public Health of the Harvard University Medical School.

The head of the Division of Organic Chemistry will be Dr. Erhard Fernholz, formerly of the University of Goettingen and Princeton University, and more recently with the research laboratory of Merck and Company. Associates in this Division are Dr. Homer E. Stavely, formerly research fellow in the Sterling Chemistry Laboratory at Yale University, and Harold B. MacPhillamy, a graduate student in the organic chemistry department of Columbia University.

Dr. Hans Jensen, formerly of the Institute of Experimental Biology of the University of California, will be associate in charge of the biochemical laboratory. Dr. Jensen is a former assistant professor of pharmacology at Johns Hopkins, where he cooperated with the late Professor John Jacob Abel in purifying and crystallizing insulin. Dr. Sibylle Tolksdorf, who also has been engaged in research at the Institute of Experimental Biology of the University of California, will be assistant in the biochemical laboratory.

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During the past three years, more than seventy original articles dealing with the uses of 'Benzedrine Sulfate Tablets' (amphetamine sulfate, S.K.F.) have appeared in medical and scientific publications.

The following would seem to be of especial interest at this time.

## **NARCOLEPSY**

ULRICH, H.: Narcolepsy and Its Treatment with Benzedrine Sulfate—New Eng. J. Med., 217:696, 1937.

## **GASTRO-INTESTINAL EFFECTS**

MYERSON, A. and RITVO, M.: Benzedrine Sulfate and Its Value in Spasm of the Gastro-Intestinal Tract—J.A.M.A., 107:24, 1936.

## **POST-ENCEPHALITIC PARKINSONISM**

DAVIS, P. L. and STEWART, W. B.: The Use of Benzedrine Sulfate in Post-Encephalitic Parkinsonism—J.A.M.A., 110:1890, 1938.

## **DEPRESSION**

WILBUR, D. L.; MACLEAN, A. R. and ALLEN, E. V.: Clinical Observations on the Effect of Benzedrine Sulphate—J.A.M.A., 109:549, 1937.

WOOLLEY, L. F.: The Clinical Effects of Benzedrine Sulphate in Mental Patients with Retarded Activity—Psych. Quart., 12:66, 1938.

## **MISCELLANEOUS**

REIFENSTEIN, E. C., JR. and DAVIDOFF, E.: The Treatment of Alcoholic Psychoses with Benzedrine Sulfate—J.A.M.A., 110:1811, 1938.

HILL, J.: Benzedrine in Seasickness—Brit. Med. Jour., ii:1109, 1937.

LESSES, M. F. and MYERSON, A.: Human Autonomic Pharmacology. XVI. Benzedrine Sulfate as an Aid in the Treatment of Obesity—New Eng. J. Med., 218:119, 1938.

Present Status of Benzedrine Sulfate — Report of the Council on Pharmacy and Chemistry — J.A.M.A., 109:2064, 1937.

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### TO THE MEMBERS OF THE WOMAN'S AUXILIARY:

As your president for the coming fiscal year, I extend to you greetings and my best wishes for a happy and busy year. In looking over the year book one cannot but realize the amazing growth of this organization. In view of the marvelous work that has been achieved by my predecessors, I can only hope to do as well; but with the support and cooperation of each and every member, I will look forward and do my very best.

The annual board meeting and luncheon was held in Orlando on October ninth with three members of the advisory board present, Dr. Gordon Ira presiding, at my request. At a roundtable discussion after lunch, Doctor Spiers joined us and I am giving you their charges for this year.

1. Examination of domestic servants and periodic health examination for all.
2. Readiness to cooperate in legislative matters and become informed about Socialized Medicine.
3. Cooperate with Tuberculosis Association.
4. Cooperate with The Auxiliary to the Southern Medical Association in the Jane Todd Crawford Memorial Scholarship Fund.
5. Establish Regional Auxiliary meetings at the time of medical meetings.
6. Have Health Institute Day.
7. Secure A. M. A. broadcasts over local stations and urge the schools to allow pupils to listen and use in science classes.
8. Cooperate with Cancer Field Army.
9. Prepare exhibit for the State Medical meeting.
10. Secure Health Education Program of the National Auxiliary from Mrs. V. E. Holcomb, 1635 Quarrier Street, Charleston, W. Va.

These things that we have undertaken to do will be of interest to all doctors' wives and some of them to all humanity.

It is my earnest desire that this Auxiliary, in its cooperation with the Florida Medical

Association, may serve the purpose for which it was organized.

My best wishes go to each and every member, and I assure you that I shall be glad to serve you at any time that I have an opportunity.

Sincerely,

(Signed) LOUISE B. WALTERS, *President.*



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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Dis- tricts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not In- cluded in First Column	Members	
						Total	Paid
Northwest District (A) Marianna 1939	Bay	W. J. Blackshear, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'40 Carol C. Wobb, M. D., Pensacola	11	100%
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		44	43
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		<i>Santa Rosa</i>	8	100%
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	16	14
	Leon-Gadsden-Liberty- Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	<i>Calhoun-Franklin-Gulf</i>	39	37
North Central District (B) Ocala, 1939	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanco Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	17	14
	Madison	E. Long, M. D., Madison				3	2
	Taylor	Ralph J. Greene, M.D., Perry	W. J. Baker, M. D., Foley	Last Friday 8:00 P. M.	<i>Baker-Dixie-Hamilton- Lafayette-Suwannee</i>	8	6
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Marchant, M. D., 224 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M. D., McIntosh	28	24
	Marion	Carney W. Mims, M. D., Commercial Bank Bldg., Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	100%
	Pasco-Hernando- Citrus	Samuel C. Harvard, M. D., Brooksville	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		15	100%
N. E. District (C) Falmouth 1939	Sumter	Clyde L. Carter, M.D., Wildwood		2nd Tuesday	<i>Bradford-Gilchrist- Levy-Union</i>	4	100%
	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	167	157
	St. Johns	J. J. Spencer, M. D., 32 Saragossa St., St. Augustine	Vernon A. Lockwood, M.D., East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	<i>Olay-Nassau</i>	10	100%
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganious, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M. D., Daytona Beach	10	100%
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.		39	38
					<i>Flagler</i>		
Southwest District (D) Lakeland, 1939	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St., Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	107	102
	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	8rd Tuesday 7:00 P. M.		14	100%
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		90	100%
	Sarasota	O. H. Crabbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		15	14
	DeSoto-Herde- Highlands-Charlotte-Glades	L. W. Martin, M.D., Sebring	Howard V. Weems, M.D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M. D., Lakeland	21	19
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	12
South Central District (E) Sanford, 1939	Polk	W. W. Shafer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	<i>Charlotte-Coller- Glades-Hendry</i>	66	57
	Brevard	G. E. Christie, M.D., Titusville	I. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M. D., Cocoa	12	100%
	Lake	Harry T. Fenn, M. D., Mount Dora	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		18	100%
	Orange	H. A. Day, M.D., 209 Exchange Bldg., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		73	100%
	Seminole	J. N. Tolar, M. D., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	<i>Osceola</i>	13	100%
	St. Lucie-Okeechobee- Indian River-Martin	R. C. Boothe, M.D., Ft. Pierce	Adrien M. Sample, M.D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	16	100%
S. E. District (F) W. Palm Beach, 1939	Broward	A. B. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M. D., West Palm Beach	31	100%
	Palm Beach	V. M. Johnson, M.D., Good Samaritan Hospital, W. Palm Beach	J. R. Sory, M.D., 616 Harvey Bldg., West Palm Beach	4th Monday 8:00 P. M.		58	100%
	Dade	Arthur H. Welland, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzor, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	286	279
	Monroe	Harry C. Galey, M. D., 632 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	100%

The swaddled infant pictured at right is one of the famous works in terra cotta exquisitely modeled by the fifteenth century Italian sculptor, Andrea della Robbia. In that day infants were bandaged from birth to preserve the symmetry of their bodies, but still the gibbous spine and distorted limbs of severe rickets often made their appearance.



*A bambino from the Foundling Hospital, Florence, Italy,—A. della Robbia*

Glisson, writing in 1671, described an ingenious use of swaddling bands — "first crossing the Brest and coming under the Armpits, then about the Head and under the Chin and then receiving the hands by two handles, so that it is a pleasure to see the Child hanging pendulous in the Air . . . This kind of Exercise . . . helpeth to restore the crooked Bones. . . ."

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Hundreds of years later swaddling was still prevalent in Italy, as attested by the sculptures of the della Robbias and their contemporaries. For in-

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# The JOURNAL of the Florida Medical Association, Inc.

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Florida Medical Association, Daytona Beach, May 1, 2, 3, 1939  
Southern Medical Association, Memphis, November, 1939



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## THE MANAGEMENT OF SINUSITIS

ORVILLE N. NELSON, M. D.,  
Bay Pines.

A normal nose should have a straight septum which is thin and in the middle line. The turbinates are of equal size and there should be an equal space on both sides of the nose for normal breathing and drainage. The nose and sinuses are lined with a mucous membrane having ciliated epithelium and serous and mucous glands. The mucous glands, which do most of the lubricating, give this lining its special name, that of mucous membrane. Without this moistening and lubricating apparatus, the mucous membrane of the nose, throat, and upper respiratory tract would dry from the constant passage of air over it.

Normally the mucous membrane of the nose and sinuses is covered with a viscous layer of mucus that is constantly moving along by the action of cilia, which move in one direction. This direction is backward in the nose and upward in the respiratory tract in order to carry the secretions into the throat. These secretions are either expelled or swallowed. This mucus layer acts as a blanket to the mucous membrane of the nose and sinuses. Bacteria cannot lodge as long as this mucus coat covers the epithelium of the passages. This movement of the mucus blanket in the nose and sinuses may be compared to the movement of an escalator. The sinuses are normally ventilated by the difference of air pressure within the sinuses from that on the outside. The mucous glands are fewer in number within the sinuses than in the lining of the nose, but are, nevertheless, sufficient in number to make the mucus coat. The mucous membrane of the sphenoid sinus contains very few mucous glands.

Colds in the head frequently develop as a result of digressions such as loss of sleep, overwork, exposure, and chilling and fatigue, which are reflected in a vasomotor reaction within the nose. This acts by shutting off one side of the nose, causing a feeling of stuffiness and thus making the other side do all the

work. The mucous membrane gets dry and the accumulated mucus does not move along in a normal manner. The cilia also dry and later die. The mucus blanket does not move along normally. The bacteria always present in the nose now have a chance to attach themselves to the mucous membrane and start an infection. The sinuses to a certain extent become infected in every cold because the lining of the nose is continuous with that of the sinuses. They may fill with secretion or pus and, if this cannot readily drain into the nose, pain results. Because of the fact that sinuses are infected the large amount of secretions which accompany head colds come in a great part from these areas.

Every general medical practitioner treats these acute colds and sinus infections, and rightfully so. These patients can be relieved in nine out of ten cases by conservative measures such as bed rest, forcing fluids, light diet, purgation, aspirin, salicylates or pyramidon. When the congestive stage is past, other helpful measures are ichthioldine intranasal tampons, mild cocaine-adrenalin intranasal tampons, weak solutions of argyrol and glycerine intranasal packs, steam inhalations with or without medicinal inhalants, bland nasal oils with or without small amounts of ephedrine added, and physiotherapy treatments.

However, assuming that the measures mentioned above have been carried out for a period of ten to twelve days without much improvement to the patient, the question then arises: what is there to do next. The patient has now acquired some immunity to his first infection and it will be safe at this time to perform conservative indicated surgery. A good procedure at this stage is to infract or dislocate the middle turbinate toward the midline which enlarges the normal drainage angle and gives better natural drainage. This simple procedure, together with the intranasal packs of ichthioldine or argyrol in glycerine, often relieves the condition.

At times the simpler measures fail to clear up the acute sinus infection and the disease progresses to the subacute and chronic stages with the formation of pus which cannot sufficiently drain through the natural openings. Pain associated with sinus disease is due to



FIG. 1. Anterior-posterior view—Pansinusitis, bilateral. All the sinuses are opaque.

the filling of the sinus with infected secretion and its failure to drain. In frontal sinusitis the pain is above the eye, beginning in the morning or mid-afternoon and lasting a few hours until the pus has drained into the nose. In other words it is a day pain. Severe pain over the frontal sinus which occurs at night is usually due to neuralgia. Antrum pain also is a day pain but its periodicity is not so marked as in the pain associated with the frontal sinus. In both cases the infected sinus is usually tender to pressure.

If the pus has localized in the antrum further measures which may now be employed are antrum irrigations, either through the natural opening or through one made under the inferior turbinate. It is preferable not to irrigate the antrum much oftener than once a week unless there is pain. The reason for not washing the sinus too frequently is to prevent waterlogging of the mucous membrane. If after three or four sinus washings there is no improvement in the amount of pus in the antrum, it is recommended that an intranasal antrum window operation be done for more permanent drainage and aeration. The sinus now drains into the inferior meatus of the nose. If the antrum infection does not clear up following this procedure but becomes chronic, with thickened mucous membrane and continued suppuration, then it is recommended that a Caldwell-Luc operation be done, removing every portion of the diseased mem-

brane. The Caldwell-Luc operation goes further than just establishing drainage. In this operation the diseased mucous membranes within the sinus are completely removed and the medial wall of the antrum removed to establish good postoperative drainage into the nose.



FIG. 2. Anterior-posterior view—Pansinusitis, right side. All the sinuses on the right side are opaque. Sinuses on the left side clear.



FIG. 3. Large size Ritter dilator in the antrum through an opening made in the intranasal antrum window operation.

The common causes of chronic maxillary sinusitis are the ordinary acute sinusitis following colds and influenzal infection going over into the chronic form, or an infected molar tooth. The infection spreads from the



diseased tooth to the maxillary sinus on the same side. The infected sinus of dental origin is treated by removing the infected tooth and establishing surgical drainage. One thing that suggests an antrum infection of dental origin is the bad odor of the pus in these cases. X-

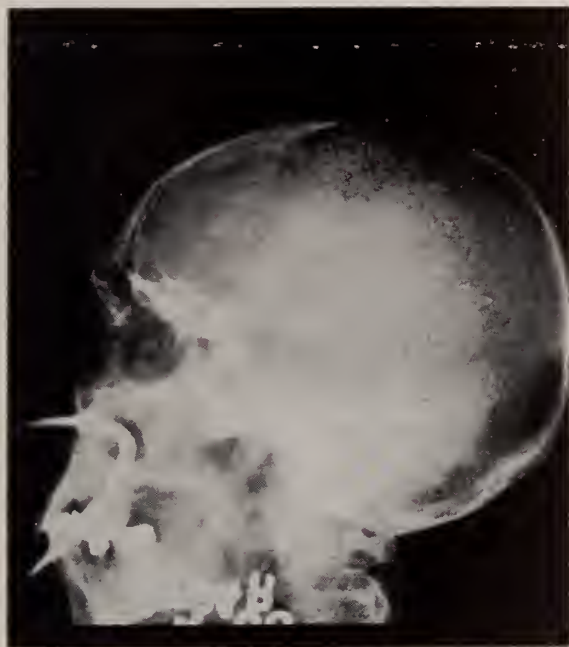


FIG. 4. Opaque catheter in maxillary sinus through openings made in the Caldwell-Luc operation on the antrum.



FIG. 5. Lingual root of first molar tooth with abscess extending into maxillary sinus.

rays of the teeth are a valuable aid in helping to determine the relationship of the teeth to the infected antrum.

When the sinus infection localizes and becomes chronic in the frontal, ethmoid, and sphenoid sinuses this requires more extensive intranasal surgery. These sinuses cannot be punctured and irrigated in the same manner

as described for the antrum. The natural communication between the frontal sinus and the nose is not very large. This normal opening is in the infundibulum. It is sometimes open and sometimes closed. The frontal duct may be straight or it may be curved, and frequently it is entirely surrounded by anterior ethmoid cells. In order to introduce a wash tube into the frontal sinus duct, it is often necessary to enlarge its opening and free the passage of the anterior ethmoidal cells about it. An intranasal frontal ethmoid exenteration well done establishes good surgical drainage. It is recommended that the middle turbinates be preserved whenever possible. If the septum of the nose is considerably deflected and thickened, it is advisable to perform first a submucous resection operation in order to get sufficient room to do a good frontal ethmoid exenteration.

The pus in the ethmoids, frontal and sphenoid sinuses is generally thin and runs out easily. A good rule to follow is that if the anterior ethmoid cells are exenterated it is just as well to exenterate the posterior group at the same time because they, too, are usually infected. Having exenterated the anterior and posterior group of ethmoids, the operator is now back to the anterior wall of the sphenoid. When the sphenoid is likewise infected, drainage of the infected sphenoid sinus is accomplished by removing the anterior wall of that sinus and curetting out the diseased membrane.



FIG. 6. Medium size Ritter dilator in the anterior and posterior ethmoids through the opening made in the intranasal anterior and posterior ethmoid sinus exenteration.





FIG. 7. Medium size Ritter dilator in the frontal sinus through opening made in the intranasal frontal anterior ethmoid sinus operation.

For the persistent, chronic cases in which there is no improvement with intranasal surgery, more radical operative procedures are required. The external-radical-frontal-ethmoid and the external-radical-frontal-ethmoid-sphenoid operations extirpate all the membranes and ethmoid cells as completely as possible. When the antrum is also chronically diseased a Caldwell-Luc operation is done at the same time. The combination of these two operations at one sitting may rightfully be called pansinusectomy. In bilateral chronic pansinusitis cases, one complete side is done at one sitting and, after a period of post-operative recovery, the same procedure is carried out on the other side.



FIG. 8. Large size Pratt ethmoid curette in the sphenoid sinus through openings made in the intranasal anterior, posterior ethmoid sinus and sphenoid sinus exenteration, having made an opening through the anterior wall of the sphenoid.

If sinus surgery is to accomplish the desired results good postoperative care is essential. This frequently marks the difference between a successful operation and a failure so far as the end results to the patient are concerned. Proper, careful, continuous, and conscientious postoperative care by the surgeon who performed the operation cannot be too strongly emphasized.

In conclusion, let me emphasize that, because of the well known fact that sinus infections frequently recur when patients contract repeated colds, a great number of these patients will require submucous resection to maintain normal ventilation and drainage if we are to expect lasting improvement.

*U. S. Veterans' Administration.*

## DISCUSSION

*Dr. J. M. Ingersoll, Miami:*

I have listened to this paper with much interest. It is concise. The indications for the various lines of treatment are stated clearly.

I think the sinuses do not become infected in every case of acute rhinitis. They are inflamed in every case and infected frequently.

The apparent increase in the amount of secretion from the nose is dependent largely upon the interference with its physiological function, at first. The normal nose secretes about one pint of serous fluid in twenty-four hours. With normal nasal respiration this fluid is absorbed by the inspired air so that when this air reaches the pharynx, trachea and lungs it is saturated with moisture. When the turbinates are inflamed the amount of secretion is increased, the nasal respiration is interfered with and the normal moisture is not absorbed but drips from the nose. Of course, any inflammation in the sinuses increases the total.

Personally, I think intranasal tampons in acute inflammation of the nose are contraindicated. They are a foreign body placed against an already inflamed delicate membrane and add to the irritation. When the tampons are removed, the relief is so great that the patient, by contrast, thinks he has been benefited.

It seems to me that the more rational treatment of the delicate, inflamed nasal mucous membrane is gentle spraying with normal saline solution to remove the accumulated secretion. The addition of some one of the good alkaline preparations colors the saline solution and produces a better mental effect on the patient. Following this cleansing solution, the application of some one of the standard ephedrine solutions either as a spray or dropped into the nose contracts the turbinal tissue, decreases the hypersecretion, provides better drainage and thus decreases the probability of sinus infection. Cocaine in such solutions is absolutely contraindicated.

The necessity for operative work, as Doctor Nelson says, must depend on the progress of the case. If the sinus infection does not improve and clear up entirely, then the sooner good drainage is established, the better the prognosis. In practically every case of acute sinus infection there will be recovery, if good drainage and aeration are established early. Chronic cases must be treated more radically. Bad odor from the pus suggests bony necrosis, not only from a tooth but also of the sinus walls. A submucous septal operation, after all acute symptoms have subsided, often provides the necessary drainage for the sinuses, prevents recurrent sinus infection, and obviates the necessity of

more radical sinus operations, as Doctor Nelson has stated.

It is hardly necessary to say that all operative work on the nasal accessory sinuses is in an anatomical region for which we should have great respect. The close relation of the sinuses with the brain, the eyes, the various nerves and blood vessels makes the operative field one which should be approached only with skill and precise anatomical knowledge.

I wish to emphasize Doctor Nelson's statement that good postoperative care is essential for accomplishing the desired results.

*Dr. R. Renfro Duke, Tampa:*

I enjoyed Doctor Nelson's paper very much and think that he has ably covered the subject. Doctor Nelson mentioned a cold as the usual forerunner of sinusitis. It has been my experience that an ordinary cold is not so often the etiological factor in producing sinusitis as the influenza infection.

In treating the patient during the acute stage of congestion, it is better to refrain from the use of local applications, such as astringents and the numerous nasal packs, which are so frequently employed. I find the best treatment is to put the patient to bed, administer a saline cathartic and liquid diet. Sprays and nasal irrigations during the stage of turgescence endanger the middle ears and are followed by reaction. The most important thing to prevent complications is to have the patient remain in bed for two or three days or even longer if the acute condition has not subsided. After the stage of engorgement has passed the astringents and argyrol packs used about the ostium are of value. By this means the swelling and infiltration of the soft tissues is relieved, thereby producing drainage and ventilation, which brings about resolution. Suction is of value where we have reason to believe the ostium is closed.

Before a patient is subjected to a sinus operation the diagnosis should be very carefully made. Transillumination is of great value; x-ray should be employed in most cases and if still in doubt the patient should be referred to an allergist for a check. Many patients have been operated for sinus infections when the true diagnosis was an allergic condition. If we can see the patient early enough, seldom is it necessary to operate. Usually they can be cured without operative interference. However, some must be operated upon. The operation of choice for the maxillary sinus is the intranasal or window operation. Be sure the window is sufficiently large for it is the adequate ventilation that effects the cure. The intranasal is also the one of choice for the frontal sinus. It has been my experience that it is not necessary to resort to the radical operation in more than five to ten per cent of cases for any of the nasal accessory sinuses.

*Dr. M. A. Lischkoff, Pensacola:*

This is a rather large subject to cover in such a short time, and I think Doctor Nelson has done it admirably. There are a few points I wish to discuss, or at least mention: first, pressure displacement treatment by Proetz. I will just mention this, as I imagine he uses it, but due to the limited time and short paper probably left it out. Many patients with normal sinuses believe that their nasal symptoms are due to sinus disease, and because treatment gives no improvement, treatment of sinusitis falls into disrepute.

The management of any pathological condition—and sinusitis is no exception—depends on accurate and precise diagnosis. This is especially true in sinus disease, whose exact nature is not always easy to ascertain. We classify our treatment into constitutional and local. In regard to systemic care, we should remember that when the patient is physically up to par, his resistance to bacterial infection is adequate. But body hygiene, the state of the endocrines and intestinal functions, are important considerations.

Our concern is, in the main, with local treatment which is essentially the promotion of adequate ventilation and drainage of the sinuses. Proper ventilation and drainage are the (sine qua non) sheet anchors of local sinus care. I wish to call your attention especially to treatment with physiotherapy. Physiotherapy, once the mainstay of the cultist, has been thoroughly studied and placed on a high plane as an adjunct to ethical therapeutics.

Physiotherapy may be variously applied but the only effective methods are those whose therapeutic effect lies in the local heat produced. Hertzian waves, the ultra-short, the short and long radio waves, and the high frequency current, are all thermal in action. Energy in the Hertzian field is applied both medically and surgically, the therapeutic heat being produced by the high frequency generator; ordinary diathermy by one to two million oscillations per second; short wave diathermy with ten to one hundred oscillations per second; and by electro-magnetic induction diathermy.

The work of Andreen and Osborne of Chicago, by an ingenious and well-controlled series of experiments on human patients with normal sinuses, has revealed the effect on temperature of the sinuses by the application of various methods of physiotherapeutic heating. Through hard rubber cannulas placed in the antrum a calibrated thermo-couple was introduced and placed next to the antral wall. Accurate measurements of the temperature of the antrum were made after the use of the conventional diathermy, short wave diathermy, and electro-magnetic field, infra-red rays, the compsolite, the Cutler water-cooled infra-red lamp, and the Elliott apparatus for treatment with hot water. They found that the electro-magnetic field and ordinary diathermy made the best record. The actual rise in temperature of the normal antrum after twenty minutes' treatment was from 98.2° to 99.1°, an average increase of 0.9 degrees. They made no clinical evaluations of their experiments.

My observations with the use of Hertzian waves leads me to believe that although heat is the only therapeutic agent it is more rapid with this adjunct and there is possibly some bacteriocidal action in the heat.

Some feel that short wave therapy suppresses sympathetic impulses and stimulates vagotonic impulses which lead to more permanent dilatation of the capillaries.

There is no doubt that the intelligent application of physiotherapy will produce satisfactory clinical results.

*Dr. Joseph W. Taylor, Tampa:*

I do not see much excuse for chronic sinusitis. We used to see many chronically infected ears but when we learned to take care of the acutely infected ear the old discharging "chronic" ear gradually became a thing of the past. So it is in sinusitis. We should remember this and not neglect acute colds. If we treat them they may last two weeks, and if we do not treat them they may run on. I don't think that it makes much difference about that. However, the fact is that if a cold has had time to be relieved and the discharge in the nose and cough continue for more than a couple of weeks you can rest assured there is sinus infection.

I examine the patients with the aid of a cannula through the natural opening guided by the nasopharyngoscope. This can be done very easily. When we find a great deal of pus in the maxillary sinuses they have to be taken care of, but I find that the ethmoids and frontals will take care of themselves. That is especially true of the ethmoids. Even in acute conditions there is no excuse for going into the ethmoids, and only into the frontals when the pain is severe.

As to the chronic condition, the less we can do in the way of destruction and removal of mucous membranes, the better for the patients. After you have established proper drainage, I think a well-made vaccine is our best bet for relieving these cases, and it should be given over a long period of time.



I enjoyed Doctor Nelson's paper very much. I think that sinusitis is one of the most important diseases that we have to deal with, and it should be dealt with early; then we can avoid chronicity.

*Dr. O. N. Nelson (Concluding):*

I want to thank the members of the Association for their kind discussion of the paper.

I certainly feel that sinus therapy should be conservative whenever possible. There is no question at all that in some sections of the country they do have to do a lot more surgery to get good results in their chronic sinusitis cases. The climate and sunshine here in Florida, however, are real aids in the management of such cases and I feel that largely because of this we do not have to perform external radical operations as frequently as, perhaps, is done in other sections of the country.

I wish to thank Doctor Duke for bringing up the point in relation to acute colds. I did not mean to infer that we used packs in acute colds and acute rhinitis. It happens that our patients are generally admitted to the hospital after they have been ill for a number of days at home. Often we are able to avoid surgery by treating them conservatively with local treatments and physiotherapy.

Thank you very much.

## RELATIONSHIP OF INTRINSIC CARCINOMA OF THE LARYNX TO PRECANCEROUS LESIONS

R. E. REPASS, M. D., and

C. S. McLEMORE, M. D.,

Miami Beach.

Before presenting a case, which demonstrates the possible relationship of carcinoma of the larynx to precancerous lesions, we wish, first, to present a brief review of the English literature pertaining to this subject.

### HISTORY

Patrick Watson of Edinburgh removed the first human larynx in 1868. He operated upon several patients the following two years and they all died. Billroth in 1873 removed the larynx of a man, who survived several months. Frederick Lange of New York removed the first human larynx in this country. The patient was the senior member of the Anheuser-Busch Company of St. Louis and the operation received considerable notoriety. The patient was led to terminate his life a week following the operation, so it met with disfavor. In 1892 Solis-Cohen removed the larynx and for the first time in this country attached the severed ends of the trachea to the skin. He remained with this patient constantly for the first 80 hours. The patient was alive three years later. The past 40 years

has seen great strides in the development of surgery of the larynx. The cases of Thomson, Jackson, Beck, MacKenty, New, and others are living proofs that surgery of the larynx has attained a definite place in the field of laryngology.

### INCIDENCE

Cancer of the larynx accounts for about 1.8 per cent of the total deaths due to malignancy; malignancy accounts for about 10 per cent of deaths from all causes. The age incidence is between 40 and 60. However, there are several cases reported of patients as young as 18 and one 15 years of age. The ratio of male to female is 10 to 1,—that is 10 males to 1 female. Postcricoid carcinoma has been found to be much more common in women than in men. Since 1908 MacKenty has studied 700 cases of cancer of the larynx and he states that 80 per cent of these cases were intrinsic. MacKenty found that 96 per cent of his cases were squamous cell, 2 per cent basal cell, 1 per cent papillary, and 1 per cent adenocarcinoma. Today, it is the general belief that moderate use of tobacco and alcohol and over-use of the voice plays no part in the production of cancer of the larynx.

### DIAGNOSIS

Most discussions of cancer of the larynx begin and end with an emphasis on the great importance of an early diagnosis. There is no place in the body where cancer offers such a chance of cure as does intrinsic cancer of the larynx when diagnosed early. Hoarseness is the first and constant symptom of intrinsic carcinoma of the larynx. In one large series, it was found that hoarseness was disregarded for three years or longer in 21 per cent of the cases. The patients were not alone to blame for this neglect, as many had been attended at regular intervals by their family physician and some by nose and throat doctors. Until the layman and the medical profession become aware of the fact that chronic hoarseness in an individual past 40 means cancer, unless proved otherwise, little can be expected in the way of early diagnosis. Practically all cancers of the larynx can be diagnosed, or at least suspected, by indirect laryngoscopy. A one-sided infiltration suggests malignancy, tuberculosis or syphilis. Impaired mobility of a cord is not necessary or frequent and never an early sign of intrinsic carcinoma. Tuberculosis of the larynx, in the vast major-

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ity of cases, is accompanied by pulmonary tuberculosis. Thomson feels that in the case of a suspicious lesion of the larynx, one is justified in waiting until he is sure of the diagnosis. The progress of a malignant disease is usually continuous. Thomson states that it is usual for him to watch a case for three months and one case he watched for nine months before operating and got a complete cure. Today, it is generally known that intrinsic carcinoma of the larynx is very slow growing, but it is not our policy to wait long before doing a biopsy. From a differential standpoint, one must consider laryngitis, keratosis, pachydermia, perichondritis, benign neoplasm, blood clots, laryngeal palsy, syphilis, and tuberculosis. When all other diseases are ruled out, one is justified in taking a biopsy of the lesion but if this is diagnosed as benign, the patient should be kept under observation until the lesion has completely healed and the voice has returned to normal. Whether the lesion is diagnosed as intrinsic or extrinsic depends entirely on its position. Intrinsic includes these growths upon the vocal cords, (usually the anterior two-thirds), the ventricles, ventricular bands and interarytenoid region. Extrinsic carcinoma includes growths involving the aryepiglottic folds, the arytenoids, pyriform sinuses, epiglottis and postcricoid area.

#### TREATMENT

Once intrinsic carcinoma of the larynx has been diagnosed, surgical removal of the lesion is the only justifiable course. Whether the lesion is removed by thyrotomy, laryngectomy, intralaryngeal excision, or window resection, depends entirely on the location, stage and extent of the disease. Thyrotomy or the laryngofissure operation today seems to be the operation of choice for intrinsic carcinoma limited to the vocal cords. Several men have removed cancers from the larynx by the use of the high frequency cutting current, using the intralaryngeal approach. Tracheotomy and radium prolongs life and alleviates symptoms to some degree in the inoperable cases.

#### COMPLICATIONS

MacKenty lists the following complications of laryngectomy and thyrotomy: pneumonia; mediastinitis; extensive sloughing of the wound; hiccough; hemorrhage; and general sepsis.

#### PROGNOSIS

Thomson's statistics show a percentage of cures in cases of cancer of the larynx of 76 per cent and Jackson's statistics show 79.3 per cent in patients undergoing surgery. When no operation is performed, death is inevitable but patients have been known to live seven or eight years after the diagnosis of cancer was made. Intrinsic cancer spreads very slowly and metastasizes late, whereas, extrinsic cancer spreads rapidly and metastasizes to the adjoining lymph glands early. Enlarged and hard cervical lymph glands, of course, give a grave prognosis. A consideration of the prognosis in cancer of the larynx again brings to mind the importance of an early diagnosis. An early diagnosis of intrinsic carcinoma of the larynx offers a better prognosis for seven year cures than does carcinoma diagnosed in any other part of the body, unless it be the basal cell carcinoma or rodent ulcer of the face.

The laity and medical profession must become hoarseness-conscious, as a sign of cancer of the throat, just as they are lump-conscious, as a sign of cancer of the breast.

#### PRECANCEROUS LESIONS

A discussion of carcinoma of the larynx is not complete today without some mention of precancerous lesions. It is Jackson's opinion that precancerous lesions are of great importance and that cancer rarely appears in the normal larynx. Chronic laryngitis, keratosis, papillomas, and granulomas all form favorable soil. It is conceded by all that these precancerous lesions are very rarely recognizable, histologically. Martland states that it is unusual to see benign papilloma become malignant. Others have seen cancer develop alongside papillomas and many feel that there is a definite transition. The transition from simple papilloma into epithelioma can now be followed experimentally by the production of tar cancer and here the true precancerous stage can be studied microscopically. The chief manifestations are: epithelial hyperplasia; irregularity in size, shape and staining property of the cells; increased mitosis; and the intactness of the basal layer. Thus, a precancerous lesion. It is entirely conceivable that in the years to come precancerous lesions will be diagnosed with the same accuracy that cancer is diagnosed today.

## CASE REPORT

This is the case of a 22-year old white woman, who was first seen at the Henry Ford Hospital in 1924, complaining of "loss of voice," of three years' duration. Direct laryngoscopy revealed a papilloma of the right vocal cord. The growth was removed, leaving the cord margins intact. Pathological examination showed papillomatous masses of squamous epithelium, most of which was well differentiated. After five months of local treatment, the voice returned to normal.

This patient was next seen at the Henry Ford Hospital in 1935, ten and one-half years later. At this time she complained of hoarseness of six months' duration. Direct laryngoscopy revealed a tumor mass involving the entire left side of the larynx. Biopsy of this tumor mass was diagnosed as squamous cell carcinoma, type 3. A two-stage laryngectomy was done. Patient made an uneventful recovery but soon complained of difficulty in swallowing. She began having frequent hemorrhages from the pharynx and eighteen months following laryngectomy she expired, after a profuse hemorrhage from the trachea.

## CONCLUSION

1. The object in presenting this paper was to remind the members of this Association that intrinsic carcinoma of the larynx, when recognized early and properly treated, is highly curable.

2. Hoarseness is the first and constant symptom of intrinsic carcinoma of the larynx.

3. It is important that the medical profession, and the laity as well, become hoarseness-conscious, as a sign of carcinoma of the larynx, just as they are lump-conscious as a sign of cancer of the breast.

4. A case is presented which demonstrates the possibility that lesions exist in the larynx, which in all probability are precancerous and in the future it may become possible to diagnose them as such.

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## DISCUSSION

*Dr. Jos. W. Taylor, Tampa:*

I want first to congratulate Doctors Repass and McLemore on their excellent paper, the manner in which it is presented and the thoroughness with which the subject has been covered.

You have noticed the essayists have stressed the importance of early diagnosis. This is not only of paramount importance in malignancies but is true of many other medical problems. I wish to emphasize what has been said: that early diagnosis is essential and that any case of hoarseness that does not clear up in a few weeks when the patient is in middle life or past, must be considered as a malignancy until proved otherwise.

The ideal early diagnosis was a case seen a few years ago. This man's age was 68, a winter visitor in the state. He gave a history of hoarseness for the previous few months. A physician was consulted and he was advised to see an otolaryngologist at once. Examination:—nose and sinuses were negative. The throat so far as the tonsils, pharynx, nasopharynx did not show any trouble. With the laryngeal mirror a small tumor was seen on the anterior third of the left vocal cord. The new growth showed no ulceration and was about the size of a grain of wheat. A biopsy was taken and in removing the specimen the entire growth was removed. The laboratory reported a squamous cell carcinoma. Following removal, x-ray therapy was used with complete recovery. If we could only see these cases at this early stage there would be no necessity for thyrotomy or laryngectomy. However, it has been my experience to see most of these poor unfortunates in the inoperable stage of the disease. I am sure that the great majority of cases I have seen in the past several years are extrinsic instead of intrinsic, and in the advanced cases we usually see, even laryngectomy is out of question.

It is reasonable to believe there do exist precancerous lesions. However, I have not had an opportunity to follow a case through as Doctor McLemore has done. On the contrary, I have seen many cases with a history of papilloma years before or perhaps in the early childhood and which, past middle age, developed into a benign tumor of the larynx.

*Dr. G. E. Chandler, Miami:*

I appreciate having the opportunity of hearing this paper. It is something that is much needed in our section of Florida. Here I come in contact with a great number of these cases on the staff of the Jackson Memorial Hospital, and my experience has been that they arrive there too late. That is also true of most cases in my office practice. The trouble is, the patient has hoarseness so long and neglects to have it attended to. He just dismisses it as a cold. That is one of the reasons for cancer of the intrinsic type, not diagnosed early enough as stated by Doctor McLemore.

Every case of hoarseness that has exceeded thirty days but has not reverted to an absolutely normal voice should have not only an indirect examination of the larynx but should have a laryngoscopic examination; that is, placing the patient in a horizontal position and exposing the entire area of the vocal cords with special instruments. The posterior two-thirds of the



vocal cords may be exposed well enough to give a partial diagnosis by the indirect method but the anterior commissure is not exposed and tumors in this region are overlooked. If diagnosed early by biopsy these tumors may be treated and the patient saved from passing into the advanced stages.

Certainly intrinsic cancer stays in the larynx a long time and is often overlooked. However, many of them become extrinsic.

I realize the essayist has not had time to cover the entire subject, and I would like to mention one or two other things.

In the advanced cases a great deal of good can be accomplished by use of the x-ray. This is usually advocated in the advanced cases when we don't know how much we can do for them; the glands are enormously enlarged, almost level with the side of the head. Usually the patient was afraid to go to the doctor for fear he would tell him that he was cancerous so he stayed away just as long as possible. But when he arrives at the point where breathing becomes difficult he then is willing to surrender. If you operate on these cases and do a total laryngectomy you have to resect all the glands of the neck as well as immediately around the larynx, resulting in recurrence of the malignancy. So you might as well turn them over to the x-ray specialist. Sometimes the patient has a family and would like to live a year or two longer.

At present I have one case of that type. The patient had been under x-ray treatment for quite some time, then it was discontinued. He would get better, then get worse, then get better again and worse. This was intracordal in type, first, but later became extrinsic. He has lived like this for almost three years, but I don't think he will be with us three months longer. (N. B. He expired in June, 1938).

Seven years ago I had another case in which I had done a laryngofissure operation but the patient died two weeks ago with tuberculosis of the lungs.

It is necessary to have a thorough physical examination of everything including the lungs before you operate on vocal cords. This was a definite squamous cell carcinoma of the left vocal cord in an insurance man. The left cord was removed. He came along very nicely and sold insurance for about six and one-half years afterwards. The last four or five months, however, he has developed active tuberculosis of the lungs and expired two weeks ago.

I would like to lay emphasis on this: any case of acute cold or laryngitis of any type that is over thirty days' duration should be referred to an otolaryngologist or someone who will do a direct laryngeal examination.

*Dr. M. A. Lischkoff, Pensacola:*

The one fact that I desire to stress that the author brought out is that the public should be made hoarseness-conscious.

Chronic hoarseness in adults results from tuberculosis, syphilis, cancer, and occasionally chronic non-specific laryngitis. Patients who are hoarse any length of time should have a careful, thorough, and complete examination of the larynx. Direct laryngoscopy should be done whenever an indirect examination leaves any doubt. Biopsy should be made of any suspicious lesion.

In early cancer with a small localized lesion and no adenopathy, the prognosis is good; but if the diagnosis is delayed till an extrinsic carcinoma is present, the outlook for speech and life is not good.

I wish to report the case of a school teacher whom I saw in consultation in May, 1933. She was 18 years of age, had been hoarse for two years following tonsillectomy. She could sing up to six months before this examination, at which time she had a brassy voice. Our clinical diagnosis was intrinsic carcinoma then, but she refused a biopsy till two years later (1935). The pathological report then was a squamous cell carcin-

oma. The mass was removed by laryngofissure. The larynx healed with ultimate restoration of voice. A very recent examination revealed a healed larynx and good voice. The patient is apparently well and able to teach school again.

*Dr. C. S. McLemore (Concluding:)*

I certainly want to thank the discussors and I agree that it certainly should be emphasized that it is the man's responsibility, who sees a case of chronic hoarseness, to view the entire larynx.

In so many cases, you can just almost see the anterior commissure, but if the anterior commissure is not seen, the patient should be subjected to direct laryngoscopy.

We left out the discussion of x-ray treatment, because it is confined almost entirely to extrinsic carcinoma. It is quite interesting that only about a year ago, Doctor Coutard made the statement that, never had he seen a case cured with x-ray or radium, after there was fixation of a cord.

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## CONGENITAL MALFORMATIONS OF THE INTESTINAL TRACT

T. C. Maguire, M.D.,  
Plant City.

Congenital malformations of the intestinal tract are of both anatomic and surgical interest, for in this condition we are confronted with the future welfare of our patient, whether it be in the newborn, or later in adult life.

I think it proper in the beginning of this short discussion of congenital malformations of the intestinal tract to review briefly the normal embryologic cell development of the body, as well as that of the intestinal tract, during the first few weeks of our embryonic life, giving the different cell formations that go to make a normal body.

There are three primary layers that give rise to all the tissues of organism, namely: the ectoderm, the mesoderm and the entoderm.

"From the ectoderm layer spring the epithelium of the outer surface of the body, including that of the conjunctiva and the anterior surface of the cornea; the external auditory canal, together with the epithelial appendages of the skin, nails, hair, sebaceous and sweat glands; the epithelium of the nasal tract, with its glands, as well as the cavities communicating therewith; the epithelium of the mouth and of the salivary and other glands opening into the oral cavity; the enamel of the teeth; the tissues of the nervous system; the retina,

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the crystalline lens, and perhaps part of the vitreous humor; and the epithelium of the pituitary and pineal bodies.

"From the mesoderm are derived the connective tissues, including areolar tissue, tendon, cartilage, bone and dentine of the teeth; the muscular tissue, except that of the sweat glands and dilator pupillae; the tissue of the vascular and lymphatic system, including their endothelium and circulating cells; the sexual glands and their excretory passages, as far as the termination of the ejaculatory ducts and vagina; and the kidney and ureter.

"From the entoderm are derived the epithelium of the digestive tract with all the glandular appendages, except those portions derived from ectodermic origin at the beginning and termination of the tube; the epithelium of the respiratory tract; the epithelium of urinary bladder and ureter; the epithelium of the thyroid and thymus bodies."

The entire digestive and intestinal tract is derived from cells coming from the ectoderm and entoderm primary cell layers. Any malformation of any part of the body, as well as that of the intestinal tract, is due to the malplacement of either of these primary cell layers in our intra-uterine development.

The cause of such malformation is a question—whether it comes from disease of the male or female organism, whether it is traumatic in character, or whether the uterine cavity is in an unhealthy state to receive and develop the embryo. Or is it just due to the misplacement of the three primary cell layers?

Dr. J. Howell Evans<sup>2</sup> has this to say of antenatal pathology: "To me, antenatal pathology has been a subject of ever-deepening interest, because it is a subject of tremendous importance for the future of the race and the individual. Antenatal pathology, being concerned with all the morbid processes which act upon the organism before birth and with the effect which they produce, may be considered from three points. First, foetal pathology; second, embryonic pathology. There is good reason to believe that morbid agencies acting on the embryo produce not diseases but malformations. When the malformed embryo becomes a foetus it carries its malformation with it. Third, germinal pathology. The lines along which the future growth is to take place are nearly all fixed during the embryonic

period—i.e., the first six weeks of intra-uterine life. Since the chief physiology of the embryo is organogenesis, or formation of parts and organs, so the chief effect of pathological processes in this embryonic or formative period is the malformation of its parts and organs."

The most common deformities or malformations that we meet in the intestinal tract are: pyloric stenosis, stenosis and atresia of the duodenum, Meckel's diverticulum, atresia of rectum, absence of colon, and ileocecal valve. The stomach is sometimes found in the thoracic cavity in cases of diaphragmatic hernia. There may be atresia at either orifice, but rarely is constriction found in the middle of the organ dividing it into two compartments.

Pyloric stenosis may be divided into two classes, hypertrophic and spasmodic. In the hypertrophic type we have an abnormal development of the pylorus, especially its transverse muscular fibres. In the spasmodic, there is a contraction of these muscular fibres, which may bring about a complete closure of the pylorus at intervals. Stenosis of the pylorus in the newborn is readily diagnosed by the character of the vomiting. The time of vomiting, after taking food into the stomach, also plays an important part as to the possible degree of closure that exists at the pylorus, and if the vomitus is clear and free from bile it is reasonably sure that the closure is at the pylorus. However, if the vomitus should contain a large amount of bile the case may be one of a stenosis beyond the opening of the bile ducts into the duodenum.

From the literature on this subject I find that congenital atresia and stenosis of the intestinal tract, exclusive of the pylorus, rectum and anal canal is a relatively rare condition, occurring in about one of twenty thousand infants. Records obtained from the Pathological Department of the University of Minnesota give fifteen cases varying in site of location as to constriction areas. Some were found in the duodenum, jejunum, ileum and cecum, and one of this number was in the colon. The obstruction is usually single. In multiple constrictions atresia and stenosis may co-exist. The point of obstruction may be narrow or moderately wide. That part of the bowel above the constriction is usually distended and in some instances so much so that

the pyloric ring is obliterated, or rupture of the bowel may occur. The bowel below the point of obstruction may be so constricted that it has a ribbon-like appearance. The symptoms of these conditions are vomiting, distention of abdomen, diminution of stools, or complete absence of stools. Here again the time of vomiting plays an important factor in locating the obstruction. It always occurs earlier when the obstruction is in the duodenum than when it is lower down in the tract. The x-ray is an important factor in diagnosing the location of the obstruction.

Probably the most common of all deformities of the intestinal tract is a condition known as Meckel's diverticulum. It is always single and is usually situated on the ileum a short distance from the ileocecal valve. However, it may occur at other points of the intestinal tract. Its structure corresponds to that portion of the bowel from which it springs.

Its calibre is generally equal to, though occasionally smaller, but rarely larger than, the calibre of the intestine above the point of its origin. It varies in length from a small nodule, or nipple-like projection, to six or seven inches. It is usually cylindrical or conical in shape, and as a rule comes off the bowel at a right angle; however, there may be an acute angle to its projection. It is sometimes attached to the umbilicus at its distal end forming a fecal fistula. Likewise, it has been known to attach itself, forming adhesions and producing an obstruction. The distal end sometimes breaks and the intestinal contents leak into the peritoneal cavity causing acute abdominal symptoms.

Atresia of the rectum and anal canal: This condition is probably brought to the attention of the physician earlier than any of the other forms of malformations of the intestinal tract, if he does not find it himself. For, as a rule, if the baby does not have a bowel movement in a short time after birth some inspection is made as to the cause of this failure. From personal experience I have found it much better to make this inspection at time of the birth of the baby than to be told of the condition by the nurse. However, those of us who do rural work are more or less handicapped, due to the fact that in the coun-

try we do not have sufficient light to make the type of inspection we should. This is because the larger part of baby delivering is done at night by oil lamps, and poor ones at that. I have oftentimes had to do this type of work by a light made from a bottle with a rag for a wick and with a room full of smoke. It is essential for the welfare of the baby whose misfortune it is to be born with an atresia of the rectum and anal opening, to have something done for it before dehydration takes place. Surgery is its only salvation.

The abnormal position of the intestinal tract is due to a faulty rotation of the midgut and is a congenital anomaly, owing to disturbances of the normal embryologic development of the intestinal tract. These disturbances may be divided into three classes: non-rotation, reversed rotation, malrotation.

"Nonrotation:<sup>3</sup> In the patient with this type of abnormality the portion of the intestinal tract which is derived from the midgut is found in exactly the same position as in an embryo 8 weeks of age. The typical anatomic findings are:

Lack of the duodenojejunal flexure.

Position of the small intestine in the right side of the abdomen.

Position of the whole large bowel in the left side of the abdomen.

Location of the appendix at the midline, or on the left side of the abdomen.

Crossing of the last loop of the ileum over the midline, from the right to the left side of the abdomen, to join with the right medial border of the cecum.

"Reversed Rotation: In this state the loops of the midgut re-enter the peritoneal cavity in the wrong order. The postarterial segment—i.e., the ascending colon, then the cecum, then the lower ileum enter, followed by the prearterial portion, thereby resulting in a rotation of the midgut which is exactly the reverse of the normal. The position now obtained is characterized by the following anatomic findings:

Position of the duodenum in front of the large bowel and the mesenteric artery, lack of the duodenojejunal flexure.

Position of the mesenteric artery in front of the colon.



Circumscribed narrowing at the middle of the transverse colon which is trapped here behind the stem of the mesenteric artery.

Normal positions of the other portions of the intestines.

"Malrotation: This condition occurs in the cases where the prearterial and the postarterial segments re-enter the abdominal cavity at the same time, the former in front and the latter behind the mesenteric artery. The characteristic anatomic findings are:

Position of the duodenum and upper jejunal loops (prearterial segments) in front of the colon and mesenteric artery.

Position of the lower small intestinal loops behind the mesenteric artery as in the normal patient.

Position of the duodenum and terminal ileum side by side, often fixed by extensive adhesions.

Presence of a very long and very narrow mesenteric pedicle on which the whole small intestine and the proximal colon (former midgut) are freely suspended.

Position of the cecum in the subpyloric region."

It is interesting to note in this connection that many patients who have some form of the above-named pathological condition in the formation of their intestinal tract may live well beyond three score and ten years with no clinical symptoms of any gastro-intestinal misfit, the abnormal condition being found at necropsy. There are others who will complain of some intestinal disorder, such as some colic pains in abdomen, belching of gas, a feeling of fullness in stomach, constipation, a feeling of lassitude, headaches, loss of appetite. Histories may also be found of long intervals of normal health and the ability to carry on work as a normal individual. It is hardly possible or probable that a diagnosis of intestinal malformation or a misplaced intestinal tract would be made with such symptoms. The diagnosis is generally made during some abdominal operation, or by means of the x-ray when looking for some other trouble.

Dr. Charles Mayo<sup>4</sup> has this to say of the nonrotation of the colon: "The relative rarity of these obscure intra-abdominal abnormalities and the fact that they so infrequently give

rise to definite symptoms explains in part why a diagnosis is so seldom made when trouble occurs."

I wish to report five cases of congenital abnormalities of the intestinal tract that I have seen, four in my own practice, and one that was referred to me by a colleague in Plant City.

#### CASE REPORTS

Case 1. An Italian baby was born early one morning after a long and tedious, though not an instrumental delivery. At the time of the birth, the child gave two or three good healthy yells, and was apparently a normal baby. I did not make an examination of the child for any abnormal condition, as it seemed to be normal. Respiration was good and its eyes open and looking around. I left the house after all details of the delivery had been completed and instructions given for the care of the mother and baby. I told them that I would see them in two days. That night, at about 11.00 p.m., I was called to the phone with the greeting that the baby had "no holey" and to come at once. I made the call and on examination of the baby found that it had a complete atresia of the rectum and anal opening. The baby was vomiting, stomach distended and he was crying as if in great pain. I operated at midnight, assisted by Dr. E. Austin, making an incision at the usual site of a normal rectum, bringing the bowel down and suturing it to the artificial anal opening. The baby was immediately relieved. It lived and developed as a normal baby until it was four and half years old. At this time it was taken suddenly sick. Its stomach was greatly distended and it died before anything could be done. The type of obstruction was not determined.

Case 2. This baby was three days old when operated upon. I was called in consultation on this case. Examination revealed the following conditions: vomiting frequently, stomach distended. I thought that we could feel a mass in lower right quadrant; small anal opening, with an obstruction about  $\frac{3}{8}$  of an inch from outer opening. The baby was very restless and showed signs of a marked dehydration. Operation was decided upon. This was done, and to our surprise we found a large distended small intestinal tract, with an appendix that was about ten inches in length, which was distended in proportion as the other part of the small intestinal tract, with complete absence of the colon. We did an enterostomy which gave the baby temporary relief. It died the following day.

Case 3. Similar to case number two.

Case 4. This baby was operated upon the second day of its life for a complete atresia of its rectum and anal opening. The same operation that was performed in case number one was used. This child is now three and one-half years of age and seems to be enjoying the best of health. However, in this case we have a vesicorectal fistula. Only a few drops of urine comes from the penis. It has not been determined whether this fistula is a congenital one or was produced at the time of the operation.

Case 5. I was called to see a young man 23 years of age, whom I found suffering intense pain in the abdomen. On questioning him as to the type of pain, and if he had had any previous attacks, he stated that he had, and plenty of them. For a number of years attacks of pain would come at various intervals, some mild and some severe. However, he had attributed it to constipation, because as soon as he could get his bowels functioning he would get relief.

On examination I found a very rigid abdominal wall. Pain increased on pressure at any point over the abdomen and the temperature was elevated. He was vomiting. The abdomen was slightly distended. With this type of history, together with the clinical findings, I



made a diagnosis of acute appendicitis and advised an immediate operation. This was done.

We had difficulty in locating the appendix, finally finding it on the left side of the median line. It was acutely inflamed, about eight inches in length, and as large around as an ordinary fountain pen, with no mesoappendix, it, lying loose in the abdominal cavity. He made the usual recovery following this type of operation and was apparently well for about six months, then began to have more of the same symptoms, i.e., pain, constipation, nausea and vomiting. He had a peculiar position that he would get into when he would come to my office. In sitting in a chair he would draw his feet up against his buttocks, knees flexed to chin. He stated that he felt more comfortable in that position than any he could get in. These attacks would last for several days, but when over them he would feel fine. He played golf and did many of the things in athletics that most young men enjoy.

Finally, he secured a position in Chicago, and while there had several attacks. Gastro-intestinal series was made. This young man had a congenital malformation of his intestinal tract, due to the faulty rotation of the midgut in his embryonic period, with the larger portion of his intestinal tract transposed to the left side of the median line. The stomach was long, its position vertical. The ascending, transverse and descending colons lay side by side in the upper left and lower left quadrant of his abdomen.

A surgical procedure was decided on to correct this deformity. The operation consisted of bringing that portion of the ascending and transverse colon over to the right side of abdomen and stitching the peritoneal covering of gut to the peritoneal lining of the abdominal wall in the upper right quadrant just below the liver and to the peritoneal lining at the crest of the ileum, thus trying to make the normal loop of the large gut. This was easily done, because of the peculiar construction of the colon. It was just a long tube held in position in the upper left quadrant by small bands of adhesions. The colon in its entirety had the appearance of a tire tube. Another interesting feature of this case was the absence of the omentum. Following this operation the patient did well for some time, and all at once he developed pain in the abdomen with vomiting and projectile vomiting on the second day. At this time a mass could be palpated in lower left quadrant. A second operation was done for an obstruction. To our surprise the obstruction was due to an adhesive band springing from the attachment of the colon at the crest of the ileum in the former operation. The colon had resumed its former position in its entirety, with two bands of adhesions across upper and lower portion of the abdomen. The obstruction was complete and gangrenous. A resection of the gut was done, but not however in time to save the life of the patient.

In conclusion, I wish to stress this one point, especially in the newborn: It is imperative that you make your diagnosis early and act accordingly, but even then your mortality rate is going to be high.

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## KNOWN AND UNKNOWN FACTORS IN TUBERCULOSIS

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It was an anonymous humorist who once said "A philosopher is one who knows everything about the unknown and nothing about the known." If such were the case we would welcome his philosophical dissertations on the many unknown factors that we now know exist in the realm of tuberculosis.

Ever since man first encountered this disease, which is thousands of years old, there has always been something about it which has defied accurate interpretation. The ancients, baffled at the etiology of the disease, laid claim to many and varied causes. Some felt it was due to the acrid secretions falling from the brain into the lungs and giving rise to this inflammation. Others thought that it was due to a disturbance of the harmony of the four interchangeable elements of the body namely, earth, water, fire and air; while still others believed it was a thing of inheritance that passed from the blood of the mother to the blood of the child. Hundreds of other reasons for the development of this disease gained recognition and it was not until Robert Koch in 1882 definitely gave us the known for the unknown and proved that the cause of tuberculosis was the tubercle bacillus. What a problem that removed from the field of philosophical speculation.

The diagnosis of tuberculosis by the ancients is a subject we may well wonder at. History and inspection were the only instruments available. In the descriptions of the disease as given by Hippocrates the diagnosis of tuberculosis was right undoubtedly in many instances, but who will deny that confused with many of the diagnoses were such diseases as bronchiectasis, pulmonary abscess and non-tuberculous pulmonary fibrosis. When Laennec came with the stethoscope he brought us closer to the known but when Koch introduced tuberculin and the sputum examination and Roentgen gave us the x-ray, then gradually the wheat was separated from the chaff—the unknown became the known.

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In the treatment of tuberculosis we find a marvelous array of fanciful therapy. There was goat milk to be taken, not at sea level but on the mountain. Then came the advocates of human milk rather than goat's or cow's milk, and that it be taken at the breast, because if air came in contact with the milk it made it less digestible. Among the ancient Romans a drink made from the shavings of the hoof of the ox, scalded with honey, was very good. An infinite number of such remedies have been handed down to us, all of them filled with much hope and little science.

It was not until Brehmer's successful showing of sanatorium results in 1854 in Germany that the institutional treatment of tuberculosis became accepted, and then came Peter Detweiler and Edward Livingston Trudeau who emphasized the importance of rest and so we find that important therapeutic measure coming to light.

When Forlinini of Italy and Murphy of Chicago, independently discovered the virtue of rest for the lung by artificial pneumothorax, there was retrieved from the unknown another factor for the control of tuberculosis, collapse treatment.

It is interesting to note that all these important discoveries have been brought to us within the past ninety years—within the lifetime of some people living today. Yet with all these wonderful advances there have arisen new problems, unknown factors that still challenge the mind of man. For instance, in experimental tuberculosis we have learned that different animals vary considerably in their response to an injection of tubercle bacilli. Now we know this occurs, but why does it occur? Why is the chicken relatively immune to the human type of tuberculosis, while the guinea pig is very susceptible? If a guinea pig is inoculated with a given dose of tubercle bacillus of the human type it soon dies from a generalized tuberculosis. The rabbit on the other hand shows more resistance, the dog still more, the cat again more, and the chicken is practically immune. But given the bovine type of tubercle bacillus, the reverse order of resistance takes place; the chicken being most susceptible and the guinea pig most resistant. If we knew the answer we might be closer to

the final solution of what constitutes resistance to tuberculosis. As we contemplate this variation in response of different animals to the same stimulus we are struck by the similarity of a related phenomenon, anaphylaxis. If a sensitized guinea pig, rabbit and dog are each injected intravenously with a given foreign protein we find the cause of death different in each one. The guinea pig dies of asphyxia, brought about by a tetanic contraction of the smooth muscle of the bronchi which blocks the intake and output of air in the lungs. The rabbit dies of a complete mechanical blocking of the circulation in the arterioles in the lungs. It is a cardiac death. The dog dies of a sudden accumulation of blood in the liver and the abdominal veins. The thing to be noted is that in three different animals with an identical stimulus we have three different responses and three different modes of death. What is at present unknown to us is, of course, the various factors involved in producing this variety of responses and we are impressed by the tremendous complexity of tissue reaction to a given stimulus.

As we travel into the field of tuberculosis in humans we have but to look back a few years and see what light has been thrown on some previously dark problems from the standpoint of understanding tuberculous infections and how they affect the individual. We used to think that a child receiving an initial infection of tubercle bacilli even sufficient to produce a large pneumonic involvement—one that would look like a typical lobar pneumonia on x-ray—was doomed to die. Anyone looking at an x-ray film showing such a large area of disturbance would naturally say that the prognosis was indeed dark. It looked like a fulminating infection. With the passing of years and with serial follow-up studies of such infections we have changed the unknown to the known and learned that these formidable-looking processes were mild and not severe and the result is practically always recovery and not death. After some months of time the pneumonic process begins to shrink and shrinks until it finally leaves nothing but calcification, a Ghon tubercle as mute testimony of its past. What a consolation it now is to point to such a lesion and be able to say: "This will resolve and leave in its wake a cal-



cification—the patient will not die but will recover.”

But once first infection has occurred, what are the changes brought about? The body becomes sensitized to the products of the tubercle bacillus and is allergic. Just as the hay fever victim, sensitive to ragweed, is harmed by too big a dose of ragweed pollen, so is the tuberculous body poisoned by too big a dose of tubercle bacilli or its products such as tuberculin. There results a more or less intense reaction around the tuberculous focus with resulting necrosis and the liberation of toxic substances into the circulation. And so we have such symptoms as fever, tachycardia, loss of appetite, loss of weight, and night sweats. These are manifestations of allergy at work. We know now that this bodily state present in the already tuberculous infected individual is the one that produces practically all the destructive types of tuberculosis. It is called the adult type of tuberculosis.

Now we know this and many other things about allergy but we still do not understand the intricate mechanism which determines the development of allergy, nor the means of preventing it. Once a hypersensitivity to the tubercle bacillus has occurred we know not how to remove it. There are many who still hope that desensitization through tuberculin will in time be practical, but so far it has failed of realization. We leave that big unsolved problem to the future.

A question that has baffled students of tuberculosis for many years is why this disease shows such a great variation in mortality rate for different age groups in male and female. Up to 5 years, the rate is about even per 100,000—84 for the male and 78 for the female. From 5 to 10 years, a definite drop occurs, 10 for the male and 10 for the female. When we come to the 'teen age a startling change occurs. The death rate for the female about doubles that of the male, 94 to 49 per 100,000. This ratio persists for a few years and then in the thirties we have the ratio about even. Then the picture changes. Deaths among the males increases so that in the age group of 45 to 60 years, there is almost twice as high a death rate in the male group as in the female.

Now why does this change in ratio occur?

That is still an unknown factor, although many explanations for it have been given. Clothes, climate, speed of life and dieting have been blamed for the increased rate among girls in the 'teen ages. There is no proof of guilt. For the increased mortality rate of both sexes during the 'teen ages Myers has brought to our attention this valuable fact, the latency of the disease.

First infection occurs and is followed by a long resting period, frequently years, before the reinfection type of disease exerts itself. Thus one infected, let us say at 7, 8, or 9 years of age may nurse a dormant infection until sixteen or seventeen years of age before the flame flares up. In analysing this we may ask why it flares up. All infections do not have the same latency. Some may take a few years and some many years. It may be due to the size of the initial infection, an overwhelming exogenous reinfection, unfavorable environment, or what not. We do not know definitely.

In considering the cause of the greatly increased mortality rate of 'teen aged girls as compared to boys this possible factor stands out: there is certainly more drive, more strain, on the girl than the boy at this period. The physiological changes of the menstrual function, plus the attendant emotional tension, plus the added striving for social or economic recognition, certainly make this period one of greater hardship for the girl than the boy. It may well be called the strain of speedy maturity.

When we come to the period after forty-five years of age we find the male struggling for economic recognition. The average housewife by this time is enjoying more or less social security. The husband is busy attempting to preserve it. And so we have struggle or strain on the one hand and relaxation on the other. Besides this, we also have to consider the increased exposures that the male undergoes at this time particularly as pertains to dangerous occupational dusts as silica, which add greatly to the increased mortality rate.

If these facts as to causes for the variation in mortality ratio are correct we can put it this way: "Speedy maturity kills, while social security saves." Perhaps that makes the difference.



Speculation has frequently centered around the endocrine glands and their part in this play. Woulf is so bold as to say that where tuberculosis threatens thyroid therapy should be instituted. Some of the symptoms of tuberculous toxemia do resemble endocrine deficiencies as of the thyroid and adrenals but how closely it is tied up to these glands is still an unknown factor. It has long been accepted that hyperthyroid patients handle tuberculous infections very well. The disease in these cases is usually a mild one becoming well localized and walled off. The myxedema patient, on the other hand, is a fertile field for the tubercle bacillus and handles the disease poorly.

In Addison's disease, one of the most frequent lesions found in the adrenals is tuberculosis. The similarity of symptoms in adrenal insufficiency and tuberculosis has been recognized. In both we have early fatigue, loss of appetite, general malaise, and a low blood pressure. Whether the toxins developed in pulmonary tuberculosis exert a depressant effect upon the adrenals is still an unknown factor.

The part played by the body minerals in tuberculosis has long been a subject of controversy. Of these, calcium has perhaps had the greatest popularity. It was formerly believed that because calcium deposits were so frequently a part of the picture of a healed tuberculous process, that this mineral was a necessary element in the healing of the lesion. Therefore, everything should be done to stimulate calcium formation. The logical way was to feed it by mouth and so calcium lactate came into popular use not only for pulmonary hemorrhages due to tuberculosis but for treating the active disease.

Proof as to the efficacy of calcium in the treatment of tuberculosis is lacking. From out of the unknown has come the fact that calcium deposition is an end result of healing and not an active agent in the healing process. After the lesion has become well walled off by fibrous tissue, the calcium is deposited in the healed lesion and there it is like so much inert substance. It is also interesting to know that in hyperthyroidism which resists active tuberculosis we have a negative blood calcium balance. Furthermore, considerable experimental work on the use of calcium in tuberculous

animals has shown no evidence that it has healing powers on these lesions.

For many years it has been recognized that the tripod upon which rested the successful treatment of tuberculosis was good food, fresh air, and rest. This tripod has of late years been given added props and it is interesting to note how good food, for instance, has been dissected into its component parts for the purpose of ascertaining which factors therein are valuable ones for bringing added resistance to the tuberculous. Let us take one factor which recently has received considerable attention—the vitamins. In the codliver oil days, when codliver oil was the grand “stand-by” in the treatment of tuberculosis, there was no explanation for its conceded value except that it was considered a good tonic. Of late years together with tomatoes it has become almost a routine treatment for tuberculous enteritis. It is believed by some at present that its rich vitamin A and D content and the vitamin C of tomato juice is the responsible factor in its value in this treatment. Whether it is we do not know. Much experimental work has been done with vitamins A and D in an attempt to prove their efficacy in the treatment of tuberculosis. Proof is still lacking that they exert any specific effect on the healing of the lesion.

Vitamin C has recently come to command much attention in the treatment of tuberculosis. Heise and his associates at Saranac came to the experimental conclusion that there was a definitely faulty metabolism of vitamin C in the body of the tuberculous and that it was possible that this vitamin did play a role in combating the disease. They did not however feel that the work up to the present justified advocating the vitamin as a curative factor.

Sweeny and his workers at the Chicago Municipal Sanatorium showed that vitamin C administration definitely improved the differential white count in tuberculosis and for that reason felt that it may be of value for the treatment of clinical tuberculosis.

Petter of Glen Lake Sanatorium found that 30 of 49 patients treated with 150 mgm. daily of vitamin C in a chocolate malt-milk drink showed definite improvement in their clinical condition.

It is still too early to definitely state the place that the vitamins hold in the treatment of tuberculosis. With all the work that is being done on this subject there does seem to be some important relationship existing between these mysterious vital factors and tuberculosis. Certainly we are doing well to consider adequately the nutritional aspect of the body and the part it plays in resistance to tuberculosis, for there is something as yet unknown that makes some bodies more fertile fields for the tubercle germs than others.

As we pass in review all the aforementioned factors that appear to play a definite relationship to resistance in the development of tuberculosis we must wonder at the complexity of the problem. It still presents many unknown aspects which time will solve and which will bring us closer to the final solution and a complete understanding of tuberculosis. Just as in the past the unknown has become the known, so in the future our present unsolved problems will come to light and show us a clearer picture.

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712 Power and Light Bldg.

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## A REVIEW OF THE LITERATURE ON SULFANILAMIDE WITH SOME PERSONAL OBSERVATIONS

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When I first received literature on prontosil and prontosil, I immediately consigned it to the waste basket as I had not then read some of the earlier works on the subject. Shortly after this my attention was called to the work of Long and Bliss<sup>1</sup> and within a few weeks I had my first experience with these drugs.

I was called to see an eight months old infant with an extensive erysipelas of the lateral and most of the anterior surface of the left thigh. The child had been scratched by a pin the day before and twelve hours before I saw him his mother noticed a small red spot at the site of the scratch which had spread to the proportions described above. His temperature was 106.6°; pulse, 120; respiration, 30; with

no other pertinent findings on physical examination. After much difficulty, I located some prontosil and prontosil in town and gave 4 cc. prontosil, 2.5% solution, intramuscularly and prontosil, gr. 5, every four hours. The next morning, the temperature had dropped to 103°, the pulse to 110, and the respiration to 26. I gave 5 cc. prontosil and continued the prontosil. There was no further spread of the infection. The next morning the temperature was 99°, and the area of inflammation had markedly diminished. Following that experience I became intensely interested in the subject.

Sulfanilamide is the name accepted by the Council on Pharmacy and Chemistry of the American Medical Association for para-amino-benzene-sulfonamide, also para-amino-phenyl-sulfonamide, and is marketed under the names: sulfanilamide, sulfonamide-P, sulfamidyl, prontosil, prontosil, stramid, streptocide, colsulanyde, prontosil album, prontosil flavum, rubiazol, and elixir of sulfanilamide which has been withdrawn from the market. Prontosil 2.5% solution is not sulfanilamide but is broken down in the body into sulfanilamide as it has the same action.

We must consider Ehrlich as the father of chemotherapy with his discovery of salvarsan. We have had many chemotherapeutic agents since but none has as wide a range of usefulness and as specific an action as this drug promises to have.

Dogmagk<sup>2</sup> in 1935 was one of the earlier workers with this drug; Levaditi and Vaisman<sup>3</sup> during this same time showed the neutralizing effect on the leucodins and hemolysins of streptococci in vitro. Buttle and associates<sup>4</sup> used six strains of streptococci on six mice for each group and showed that in five of these groups none of the control mice survived three days except one and it was killed on the seventh day and each of the treated groups had one or more mice to survive a month or longer. In the excepted group both the control and treated mice died within three days. With meningococcal infections of 100 million organisms no control animal lasted two days whereas five treated survived one month. They also showed that it had little effect on staphylococcus or pneumococcus type I.

Colebrook and associates<sup>5</sup> showed that a

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1:10,000 concentration of sulfanilamide in culture media delayed growth of thirty to fifty streptococci two to five days whereas they had been growing in sixteen hours; however, a 1:100 concentration of sulfanilamide did not affect 1 cc. of a culture of undiluted organisms containing 300 million organisms, although it did affect one-tenth this number. A 1:18,000 concentration of sulfanilamide in defibrinated blood (concentration added in vitro) killed considerable cocci. Prontosil soluble had no bactericidal power in vitro but appears to work in vivo. Blood sera of rabbits, mice, and monkeys after the administration of sulfanilamide by mouth killed small inoculum of streptococci whereas they grow freely in normal serum.

Long and Bliss<sup>9</sup> confirmed the experiments of Colebrook as described above and they believe that the mode of action is that the drug inhibits the growth of the organism and injures it in such a manner that it can be phagocytized by the white blood cells. They treated seventy patients with varied streptococci infections with four deaths. One was a 57 year old negro who died seven hours after treatment started; two were cases of Ludwig's angina wherein the patients died in twenty and thirty-five hours, respectively, after treatment began; and the fourth was a four months old infant who had received adequate treatment for twelve days when death occurred suddenly. They believe that the total twenty-four hour dosage for prontosil, 2.5% solution, is 1 cc. per pound up to 120 pounds and for prontosil three 5 gr. (1 gram) for each twenty pounds with a maximum dose of 5 grams (fifteen 5 gr. tablets) which should be given in four doses divided every six hours.

Paton and Eaton<sup>7</sup> showed that sulfhemoglobinemia occurred more frequently in cases where magnesium sulfate is used simultaneously and occasionally methemoglobinemia occurs. It takes sulfhemoglobinemia a long time to recover whereas methemoglobinemia recovers rapidly. Sulfhemoglobinemia should be treated by transfusions, glucose and saline, and methemoglobinemia by oxygen.

Marshall and associates<sup>8</sup> devised a method for determining para-amino-benzene-sulfonamide concentration in the blood and urine, the technique of which I will not go into here. They found that in dogs the blood concentra-

tion does not mount more quickly or attain a higher level when the drug is given subcutaneously than by oral administration. In patients to whom are administered large daily divided doses, one hundred per cent can be recovered in the urine when equilibrium has been reached which is usually in two to three days. It is excreted more slowly in patients with impaired renal function. After oral administration it is found in smaller amounts in the cerebrospinal fluid than in the blood.

Long and Bliss<sup>9</sup> noted no renal irritation but found that the drug was excreted as rapidly in patients with impaired renal function and should be more carefully watched in these individuals.

Schwentker, Gelman, and Long<sup>10</sup> report ten cases of meningococcic meningitis and one of septicemia with this drug in which it was injected intraspinally in an .8% solution in a physiologic solution of sodium chloride also subcutaneously with results that are comparable to specific antiserum. There was only one death and this patient had pneumonia also.

Bohlman<sup>11</sup> reports successful results in the use of sulfanilamide in the treatment of three cases of gas gangrene; he thinks that the drug has some specific effect on the B. Welchii, but this is probably due to the effect that it has on the streptococci that are growing in symbiosis with the B. Welchii.

Helmholtz<sup>12</sup> makes a comparison of mandelic acid with sulfanilamide for urinary infections and states that sulfanilamide is the drug of choice in the average urinary infection due to its tolerance and action. Mandelic acid is practically useless unless a hydrogen ion concentration of 5.5 or less is maintained, and it is impossible to reach that acidity in a Proteus infection. Sulfanilamide acts best in an alkaline urine. In streptococci faecalis infections it is advisable to use mandelic acids.

Walther<sup>13</sup> thinks that all urinary antiseptics still have their place and that it will take more study to determine which is best suited to each type of infection.

It appears that sulfanilamide has been used in almost all types of infections with exceedingly good results in some and little if any value in others. It has been used with all types of streptococci but is best with beta



hemolytic, staphylococcus, meningococcus, gonococcus, pneumococcus (best results with type III), typhoid bacillus, colon bacillus, bacillus Welchii and quite a number of others. It has also been used in two cases of quartan malaria" with a cessation of chills and fever and a disappearance of parasites from the blood.

The toxic manifestations of this drug are: headache, dizziness, nausea, rarely vomiting, sulfhemoglobinemia, methemoglobinemia, agranulocytosis, hemolytic anemia, toxic optic neuritis, varied skin eruptions and dermatitis including purpuric and scarlatiniform eruptions, photosensitization of the skin, specific febrile reactions and paraesthesias of the skin.

I have collected from the literature 698 cases of varied types of infections<sup>15</sup> with 37 cases of reported toxic manifestations not counting headache, dizziness, nausea, sulfhemoglobinemia or methemoglobinemia as the number of these cases is indefinite. This is an incidence of 5.3%. Were the other toxic manifestations enumerated I feel that the percentage would run over eighty per cent as it did in my small series that I shall mention shortly. There has been one reported death from the use of sulfanilamide (agranulocytosis), but had some of the toxic cases occurred to most of us in general practice rather than in the larger centers where they have every facility for coping with the emergency without delay I feel we might have had more fatalities. There have been a number of deaths from the use of elixir of sulfanilamide (Massengill)<sup>16</sup> which appeared to be due not to the sulfanilamide but to the menstruum that was used as a solvent, namely diethylene glycol.

I shall now go into some personal observations on the use of the drug. I have collected a series of 42 cases as follows: gonococcus infections, 25; incomplete abortion with infection, 3; pyelitis, 1; septic sore throat, 1; otitis media, 1; chronic ischiorectal abscess with colon bacillus infection, 1; puerperal infection, 1; erysipelas, 2; pneumonia with staphylococcus infection of foot and leg, 1; infantile gonococcus, 1; nonspecific vaginitis, 3; posttyphoid streptococcus infection of the neck and face, 1. Of the gonorrhea cases there was one recurrence and one reinfection. With regard to the reinfection, I had heard through dame rumor that many were getting

cures using quite a bit less of the drug than I was using so I tried this with failure, but this patient promptly recovered using a sufficient amount of the drug. I employ 100 5-grain tablets as follows: four tablets every six hours for four doses; then three tablets four times a day, meal times and bedtime, for two days; then two tablets four times a day. I use with this a like amount of sodium bicarbonate as this seems to lessen the nausea, and as a preventive for acidosis. One case was that of a woman 5 months pregnant with an associated chronic cervicitis from an old cervical laceration. The amount of discharge was very little affected but there was an absence of gonococci in the smear, a cessation of vaginal irritation and the discharge changed from a creamy yellow to a white mucoid in appearance. In the gonorrhea cases, except for the first few, I took a white blood count and hemoglobin every two days after the first visit and in this series there was a drop of from 5% to 30%. In one of the earlier cases, before I was seeing these patients every two days, I had explained the possible toxic manifestations and warned the patient to stop treatment and return to me immediately if such manifestations appeared. This was not done; he had fainted at least once every day for the three days but had continued taking the drug. When he came in, his temperature was 103.6°; red blood count, 3,100,000; white blood count, 4,000; hemoglobin 50%. I would have judged this individual to have had a hemoglobin of about 100% at the outset. Needless to say, I was exceedingly worried for the next few days.

One patient who developed a severe sulfhemoglobinemia had a rise in the hemoglobin but two days after stopping the drug there was a drop of 20%. In the nonspecific vaginitis cases, there was a cessation of the discharge during the administration of the drug but an immediate recurrence after discontinuing the drug. In the pneumonia case, I used also antipneumococcic combined serum types I and II so am unable to say which produced the effect as the sputum was not typed. I do know that the drug had no effect on the associated staphylococcus leg infection.

One incomplete abortion patient took 60 gr. and became severely cyanotic with a respiration of 30 and appeared acutely ill. The drug was discontinued for forty-eight hours and

then tried again, 20 gr. per day in divided doses with some return of cyanosis. In the case of ischiorectal abscess with colon bacillus, there was marked improvement but the drug had to be stopped twice due to severe cyanosis.

In nearly all cases there was some headache, nausea and dizziness and in two cases with a past history of gastric disturbance the patients complained severely of gastric discomfort, one refusing to take the drug and the other finding it necessary to go to bed to continue it.

We now have a new therapeutic agent of exceptional value but which has some dangerous potentialities and must not be used indiscriminately without close observation of the patient. I believe that the drug will be improved and its dangers reduced so that it will be as superior to other drugs as the neoarsphenamines are over salvarsan.

I have drawn up the following plan which I think should be used in prescribing the drug:

1. All doctors should acquaint their druggist with the dangers of the drug to discourage counter-prescribing.
2. The patient should be seen at least every 2 days, preferably every day, at which times the white blood count and hemoglobin should be taken; also the red blood count when indicated by the hemoglobin, or when there is too much discrepancy in the hemoglobin and the appearance of the patient.
3. The prescription should be *nonrepetatur* and should contain only enough drug to last until the patient is to return.

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## SALT SUBSTITUTE AIDS NEPHRITIS VICTIMS

Considerable comfort and security may be gained for the occasional nephritic patient by substituting potassium chloride for salt, M. Herbert Barker, M. D., and Roger Robinson, M. D., Chicago, point out in *The Journal of the American Medical Association* for Nov. 19.

Careful clinical and metabolic studies of fifteen patients with long-standing advanced renal disease have shown marked elevations of blood pressure, decreases of renal function and associated symptoms in nine cases whenever sodium chloride was ingested. The many sources of sodium chloride in common foods that the salt-hungry patient will naturally select when he is on a salt-free diet renders true restriction of sodium chloride difficult.

When a patient is forced to go on a low protein diet he gives up not only protein but the phosphate and sulfate ions of the meat that play an important role in the fluid balance of his body. This factor is important in the diuretic (increased urinary output) effect of the high-protein diet frequently given the nephrotic (structural disease change of the liver) patient. The chronic nephritic patient is also readily upset by changes in his mineral intake, apparently because of poor mineral metabolism or clearance.

Since the low protein diet leaves the patient chiefly fruits and vegetables, which supply base in great excess, the need for nontoxic, nonthreshold neutralizing acid elements may be desirable. Ammonium sulfate has been the most helpful of the substances used. The patient who is required to take a low protein, salt-free diet is not only kept in a better state of urea clearance, circulation and fluid bal-

ance, but the addition of ammonium sulfate may permit the taking of small amounts of salt, which renders the diet more palatable. Further, it may cover the sodium chloride, that most certainly will creep into one's food with the disastrous effects demonstrated.

## KIDNEYS AND RISKS OF PREGNANCY

It is believed that toxemia (accumulation of poisonous substances in the blood) of pregnancy will not develop if the function of the kidney is not impaired.

In stating this belief F. L. McPhail, M.D., Great Falls, Mont., in *The Journal of the American Medical Association* for Nov. 19, describes a method of treatment developed in connection with studies on water balance, acid-base equilibrium, kidney function and shifts in body water. When the burden of fetal excretion is added without a sufficient increase in fluid intake there may be a retention of urinary waste.

The treatment of mild toxemia is simple and its progress may be averted. The success of the treatment depends on the cooperation of the patient. The taking of fluids is forced. A neutral diet is prescribed. As sodium is a predisposing cause of swelling due to the retention of fluids by the tissues of the body, foods having a low sodium content are chosen, and for the same reason sodium chloride and sodium bicarbonate are eliminated.

Severe nonconvulsive toxemia is treated in a similar manner. The patient should be observed more closely, because of the severity of the symptoms. Hospital care is of great value. In the case of the convulsive toxemias, fluids cannot be given by mouth but must be given through a vein or under the skin.



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## PRE-CONVENTION MEETING

The Pre-Convention Meeting of the Florida Medical Association will be held Sunday, January 29, 1939 at the Roosevelt Hotel, Jacksonville. The Association's Committee on Scientific Work will meet at 9 a. m. All members of this committee are urged to be present promptly at the time set. The Committee will review applications received for places on the program of the Sixty-sixth Annual Meeting, to be held in May at Daytona Beach, and also arrange for the scientific programs of the six medical district meetings, to be held during 1939. Dr. Walter C. Jones, chairman, is anxious to have every member of his committee present at 9 a. m., as the work of preparing these programs will require more time than in previous years.

The Executive Committee of the Association will meet at 11 a. m. Invitations for the 1940 annual meeting of the Florida Medical Association will be considered, as required in the By-Laws. After due consideration, the Executive Committee at this meeting will recommend the place most desirable at that time, to the House of Delegates at its first regular meeting, for approval. In the event

there is no invitation, the Executive Committee will recommend the place most desirable. Dr. Gilbert S. Osincup, chairman, requests that every member of the Executive Committee be present at 11 a. m., in order that all the items of business may be transacted before the luncheon meeting.

A number of the Association's other standing committees will hold meetings Sunday forenoon. The members of such committees will receive personal notices from their chairmen.

The annual meeting of the Council will be held prior to the luncheon, scheduled for 12:30 p. m., Sunday, January 29, 1939, at the Roosevelt Hotel, Jacksonville. Councilors' reports will be read and turned in for publication in the Association's Journal. Each councilor is requested to be present and read his annual report. Councilors who find it impossible to attend this annual meeting are requested to forward their reports to Dr. Harrison A. Walker, chairman of the Council, P. O. Box 1018, Jacksonville. At this meeting the dates will be set for the annual meetings in the six medical districts. In order that there may be no conflict in the dates of these annual medical district meetings, each councilor is requested to investigate local conditions and be prepared to select the date most suitable to the doctors in his district.

Chapter VII, Section 21 requires each committee to have a report of its activities to submit at the annual Pre-Convention Meeting and to make its final report to the House of Delegates at its first annual session. Committee chairmen are not required to hand in typewritten reports at the Pre-Convention Meeting, since their completed reports for the year will be turned in at the meeting of the House of Delegates next May. Chairmen of all regular committees are requested to notify the members of their committees, in case they deem it advisable to have a meeting Sunday forenoon, January 29 in Jacksonville.

The general session of the Pre-Convention Meeting will convene at 12:30 p. m., Sunday, January 29. All members of the State Medical Association are cordially invited to be present on this occasion.



## THE CULPABILITY FOR DELAY IN THE TREATMENT OF CANCER CASES

Under the above title there appeared in the July 1938 issue of the American Journal of Cancer a statistical study of 1,000 cancer cases. The authors, Drs. George T. Pack and James S. Gallo, selected the cases at random from patients applying for treatment at the Memorial Hospital of New York City and the Lindrim Tumor Clinic of Paterson General Hospital, New Jersey. They considered as culpability on the part of the patient, delay of more than three months between onset or discovery of symptoms and first consulting a physician; or failure to accept the physician's advice so that the elapsed time from onset to the first visit at the cancer clinic was greater than three months. Culpability on the part of the physician was considered under the following headings: wrong treatment, wrong advice, no treatment, and no advice, acceptable treatment but delay in referring when no improvement resulted and inability to diagnose within one month.

The following tables of the authors speak for themselves, showing the occurrence of unreasonable delay and to whom it was due.

TABLE I A  
*Responsibility for Delay: The Group as a Whole*

Responsibility	Number	per cent
Total	1,000	100.0
(1) Patient alone	443	44.3
(2) Patient and physician	180	18.0
(3) Physician alone	170	17.0
(4) No delay	207	20.7

<sup>1</sup>Based on the 940 cases in which a physician was consulted.

The following table studies the type of criticism in those cases in which the physician erred.

TABLE VI  
*Type of Criticism of Physician in Relation to Cases of Criticism Only and to the Total 940 Cases in which a Physician was Consulted*

Type of Criticism	Cases of Criticism		Per cent Based on 940 Total
	Number	Per cent	
Total	350 <sup>1</sup>	100.0	100.0
(1) Wrong treatment	161	46.0	17.1
(2) Wrong advice	38	10.9	4.0
(3) No treatment and no advice	104	29.7	11.1
(4) Treatment, but referred later than a month	21	6.0	2.2
(5) Inability to diagnose within a month	26	7.4	2.8

<sup>1</sup>These 350 cases of criticism represent 37.2 per cent of the 940 cases in which a physician was consulted.

The message of Doctors Pack and Gallo is summarized in their remark: "Upon proper

TABLE I B  
*Responsibility for Delay in Certain Types of Cancer*

Responsibility	Breast		Cervix		Skin		Stomach	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Total	246	100.0	141	100.0	122	100.0	37	100.0
Patient alone	140	56.9	68	48.2	51	41.8	15	40.5
Patient and physician	15	6.1	17	12.1	51	41.8	8	21.6
Physician	34	13.8	18	12.8	14	11.5	9	24.3
No delay	57	23.2	38	26.9	6	4.9	5	13.5

Responsibility	Rectum		Tonsil		Tongue		Larynx (Extrinsic)	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Total	42	100.0	41	100.0	40	100.0	39	100.0
Patient	19	45.2	10	24.4	8	20.0	18	46.2
Patient and physician	11	26.2	4	9.7	13	32.5	1	2.5
Physician	6	14.3	12	29.3	5	12.5	8	20.5
No delay	6	14.3	15	36.6	14	35.0	12	30.8

<sup>1</sup>Based on 225 cases in which a physician was consulted. <sup>2</sup>A physician was consulted by all patients with cancer of the cervix. <sup>3</sup>Based on 107 cases in which a physician was consulted. <sup>4</sup>Based on 34 cases. <sup>5</sup>Based on 40 cases. <sup>6</sup>A physician was consulted in all cases of cancer of the tonsil. <sup>7</sup>Based on 39 cases. <sup>8</sup>Based on 36 cases.



diagnosis and adequate early care depends the successful outcome of many cases of cancer, such as come to us now in a hopelessly inoperable stage."

It is our duty to educate our patients to consult us without undue delay and then to see that the patient does not suffer delay at our hands. Only by so doing can the appalling death rate from cancer be attacked.

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### HAVEN EMERSON SAYS STATE MEDICINE WON'T WORK

The productive success of preventive medicine through government gives no assurance that curative medicine under government control would be equally successful, Haven Emerson, M.D., New York, declared recently in the opening address before the Columbia University College of Physicians and Surgeons, *The Journal of the American Medical Association* for Nov. 26 reports.

Medicine, Dr. Emerson said, whether curative or preventive, has more to contribute than it has ever been able to deliver in the past, and by wise organization certain still greater benefits may be assured; but to reason from the productive success of preventive medicine through government for social ends that diagnosis and treatment of the individual medical and surgical patient by or under the professional and financial control of government would similarly advance social ends or the quality of medical care, or reduce its cost, is not only questionable but on its recorded performance elsewhere is at least improbable.

It is well to pause a moment before forming a fixed opinion or committing ourselves irrevocably to a repetition of the blunders and complexities which have arrested the progress of medicine in some other lands and consider the eminence of our own present health status. Certainly no 130,000,000 people under one government or federation of states, and no aggregation of populations representative of such different races or distributed so widely under varied conditions of climate, occupation and economic status have in the recorded history of man enjoyed such relative certainty as our people of the United States do today in the survival of their offspring in infancy and childhood, or have experienced so low an incidence of the communicable diseases or so

high an average level of life expectancy. And yet in the most recent official declaration from technical committees and interdepartmental boards in Washington we read that "preventive health services for the nation as a whole are grossly insufficient."

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### EXHIBIT SYMPOSIUM ON HEART DISEASE

An exhibit symposium on heart disease has been arranged for the Scientific Exhibit at the St. Louis session of the American Medical Association, May 15-19, 1939, *The Journal of the American Medical Association* for Nov. 26 announces.

The symposium will be presented with the cooperation of the American Heart Association, under the auspices of a committee headed by Dr. Thomas M. McMillan, 2044 Locust Street, Philadelphia.

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### MEDICINE DECIDES

Assembled in an emergency session at Chicago, the House of Delegates of the American Medical Association has declared its uncompromising opposition to compulsory sickness insurance. By far the great majority of the 110,000 physician-members of the Association will concur unreservedly in this stand.

The profession's knowledge of the problem of medical care is based on many years of firsthand experience, not on a few superficial surveys and statistical tables which do not truly represent the prevailing state of affairs. Having observed the debasing effects of political control on medical service in many European countries, it is loath to see a similar system introduced here. It stands firm on the stand that quality, rather than quantity must be the aim of any acceptable medical program, and that it is folly to abandon a method of providing medical care which has reduced the morbidity and mortality rates of this country to an enviable level and is yearly driving them lower.

This does not mean that organized medicine underestimates the desirability of wisely conceived governmental health projects. The A. M. A. approves the extension of public health services, but believes they should be organized and administered by local units of government,

in accordance with local requirements. The role of the Federal government should be limited, wherever possible to the provision of financial and technical aid.

To bolster up unfounded charges of Toryism in medicine, the advocates of compulsory sickness insurance frequently charge that the profession is opposed to such valuable innovations as group hospitalization insurance. The House of Delegates spikes such misrepresentations by endorsing hospital service insurance and voluntary indemnity plans to cover the costs of emergent and prolonged illnesses.

While emphasizing the role of local governmental units in public health work, the profession is alive to the desirability and need for Federal efforts in this field. The A. M. A. therefore urges the creation of a Federal Department of Health with a physician-secretary at its head who shall be a member of the President's Cabinet. Such a department could do valuable work in planning and coordinating national health activities and could remove much needless misunderstanding and friction between Washington and the medical profession.

*N. Y. State J. M.*

#### NEW COUNTY MEDICAL SOCIETY

For a year or more the doctors in Franklin and Gulf Counties have been contemplating the organization of a new county medical society. These two counties are too far removed from any other county medical society for the doctors to attend meetings conveniently. There is a county health unit for Franklin and Gulf Counties and the doctors there feel that they need a local medical society, in order to cooperate properly.

On Tuesday, November 22, Dr. N. A. Baltzell, councilor for district number two, and Stewart Thompson, managing director of the Association, met in Apalachicola with the local doctors. Doctor Baltzell was elected temporary chairman and outlined the purpose of the meeting. The following officers were elected: Dr. Chapman Dykes of Carrabelle, president; Dr. A. E. Conter of Apalachicola, vice-president; and Dr. A. L. Ward of Port St. Joe, secretary-treasurer. A constitution and by-laws were adopted, patterned after the form prepared by the A. M. A. A formal application was signed by the following

charter members: Drs. William H. Ball, Apalachicola; L. H. Bartee, Port St. Joe; August E. Conter, Apalachicola; Chapman Dykes, Carrabelle; Thomas Meriwether, Wewahitchka; J. R. Norton, Port St. Joe; and A. L. Ward, Port St. Joe.

Three of the signers are already members of the State Association and have requested transfers from their respective county medical societies: Dr. W. H. Ball, Hillsborough County Medical Society; Drs. A. E. Conter and Chapman Dykes, Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Doctor Ball is director of the new county health unit and at the request of the local doctors, was quite active in preparing for the organization meeting. In the application for a charter, the Executive Committee of the State Association was requested to approve the organization of this new county medical society and allow its members to pay 1938 dues and function as the Franklin-Gulf County Medical Society until next May, when the House of Delegates will be asked to issue a charter.

The second meeting of the new medical society was held Friday, November 25, at Apalachicola, for the purpose of electing three censors and arranging for the time and place of regular meetings.

Mimeographed copies of the proposed fee schedule were put into the hands of all the members and a special meeting will be arranged at an early date for the adoption of a fee schedule to be used in connection with the Workmen's Compensation Act. This new medical society will bring together at regular intervals the doctors in Franklin and Gulf Counties and should be of great value not only to the doctors themselves, but to the citizens of the counties.

#### TERMINATION OF THE FLORIDA MIDLAND MEDICAL SOCIETY

At the suggestion of Dr. W. C. McConnell, president of the Florida Midland Medical Society, the "last minutes" of the society are reproduced. After twenty-two years of scientific work the members of the Florida Midland Medical Society may well feel that their purposes have been accomplished—the advancement of scientific work throughout the district and the development of good fellowship among the medical practitioners.



The State Medical Association's Southwest Medical District is almost identical with the territory covered by the Florida Midland Medical Society. This medical district is a sectional part of the State Association and under the supervision of the councilors. This independent society, composed of members of the State Association, has made a real contribution to the medical profession in the state. The sterling qualities of the doctors in this district are now evidenced by their recent action in officially disbanding the Florida Midland Medical Society and offering their full cooperation to the State Association, in developing the Southwest Medical District. Too much praise cannot be given to these fine doctors who have been so active for twenty-two years in their efforts to advance medical science and, at this crucial moment, are able to visualize the importance of cooperating and lending their loyalty to the State Association of which its members form a part.

#### MINUTES

The first entry in the original minute book of the Florida Midland Medical Society reads: "On the first Tuesday in January, Nineteen Hundred Sixteen, the following physicians met at the City Hall, Bartow, Fla., and organized the Tri-County Medical Society, comprising the counties of Polk, DeSoto and Lee." Twenty-six names comprised the roster and the following officers were elected: Dr. J. E. Brecht, Fort Myers, President; Dr. S. F. Smith, Lakeland, Vice-President; Dr. H. P. Newman, Bartow, Secretary. The Councilors were: Drs. W. R. Groover of Polk, J. A. Simmons of DeSoto and G. E. Henry of Lee County. Other meetings were held in April and July of 1916.

At the meeting of September 10, 1918, resolutions were introduced to change the name of the organization to the Florida Midland Medical Society and giving as its object "to unite the ethical medical and dental professions of the central part of Florida into a working society." These were adopted at Arcadia, January 4, 1919.

The minutes record no meetings between October 24, 1923, and May 4, 1927, and between October 25, 1934, and October 27, 1936. Since the last date, meetings have been held twice a year until the untimely death of our late Secretary, Dr. B. H. Sanchez of Plant City made completion of a satisfactory program improbable. The President felt it better to cancel the intended October, 1938, meeting at Sebring than to have one that might detract from the enviable record of the Society.

At about this time, District D of the Florida Medical Association held its second annual meeting at Bradenton. Since the two organizations cover the same territory, several members suggested a merger of them.

The President felt that his office did not empower him to make such a decision and distributed questionnaires to members. Replies confirm the opinion that the Society has completed its task after twenty-two years of scientific advancement and now casts its burden on youth, christened "District D" by its parent, the Florida Medical Association. However, a great number of replies indicate the desire to perpetuate the name of the Florida Midland Medical Society on a retired status in the form of a midsummer social get-together assembly for members and their families.

The idea of having a symposium at this meeting was deleted so often, it seems to be the wish of most members to have a purely social function once a year.

Dr. C. W. Larrabee of Bradenton extends an invitation to meet for a fish fry next summer at Larrahurst on Devil's Elbow.

#### MEDICAL DISTRICT MEETING—E

Eustis, November 10

The second annual meeting of the South Central Medical District was held at Eustis on Thursday, at 3 p. m., with the Lake County Medical Center as headquarters. There was a total registration of 70. Of this number, 50 were Association members (from this district, 43); 5 were visitors; and 15 were ladies.

Notwithstanding a rainy afternoon, the meeting was well attended. It was an unusual treat to meet in the Medical Center, instead of a hotel. The Lake County Medical Center is a great institution in the making. The local doctors, who have full control, are developing the various units as rapidly as possible. The members and guests who attended this meeting enjoyed the privilege of an official inspection and the opportunity to observe what has already been accomplished in organizing and equipping this medical center. While the official sessions were held the visiting doctors' wives were entertained by the wives of the local doctors. In the evening the doctors, their wives and guests were served in the large dining room. The main item was roast turkey, with the usual trimmings. This splendid course dinner was served by the young ladies of the Presbyterian Church choir. The excellent service rendered by these efficient young ladies gave the bountiful dinner a pleasing reception. A number of vocal and whistling solos and violin music were rendered by imported talent. At the close of the dinner, Doctor W. C. Page of Cocoa called on Doctor Spiers as the first speaker. Doctor Will L. Wood of Mount Dora introduced the guest speaker, Doctor William Perrin Nicolson, Jr., of Atlanta. Doctor Nicolson presented a paper on "Cancer of the Breast, Its Diagnosis and Management," which was illustrated with slides.

At 3:15 p. m. the meeting was called to order by Dr. W. C. Page, junior councilor. Doctor Page announced that a wire and letter had been received from Dr. H. D. Clark of Ft. Pierce, senior councilor, to the effect that he would be unable to attend the meeting on



account of sickness. On motion by Dr. Edward Jelks of Jacksonville, the junior counselor was instructed to write a letter of sympathy to Doctor Clark.

The address of welcome was given by Dr. W. G. DeVane of Groveland, on behalf of the Lake County Medical Society. Dr. Shaler Richardson of Jacksonville, secretary-treasurer and editor of the Journal, outlined briefly the work in the Association's home office, publication of the Journal, and other activities in connection with the office. At the close, Doctor Richardson brought some firsthand information from the special, called meeting of the A. M. A. House of Delegates, held in September in Chicago, which he attended. A wire was received from Dr. Harrison A. Walker of Miami Beach, chairman of the Council, regretting his inability to attend the meeting. Dr. Meredith Mallory of Orlando, the Association's delegate to the A. M. A. House of Delegates, read an official report of the special, called meeting in Chicago. This report will appear in an early number of the Florida Medical Journal. Dr. Leigh F. Robinson of Ft. Lauderdale, president-elect of the State Association, was recognized and made a few remarks.

Dr. Gilbert S. Osincup of Orlando, chairman of the Executive Committee of the State Association, reported on the called meeting of the A. M. A. House of Delegates, emphasized the importance of each county medical society adopting a legal constitution and by-laws, and also reviewed the reasons for a fee schedule in connection with the Workmen's Compensation Act. Dr. J. R. Chappell of Orlando, chairman of the Association's Committee on Medical Education and Hospitals, made a brief report. Dr. John S. McEwan of Orlando, past president, 1925, was then recognized by the Chair and, in his remarks, made the statement that the medical district meetings mean more in many ways than the annual state meeting of the Association. He said the smaller meetings are more informal and there is a better opportunity for the doctors to discuss their problems and learn of the activities of the Association. Dr. Edward Jelks of Jacksonville, past president, 1937, was recognized, and his ready wit drew the usual applause. Dr. Eugene G. Peek of Ocala, vice-president of the State Association, stated that the medical district meetings gave a better opportunity

for the doctors to rub shoulders with one another than any other meetings he attends. Dr. J. Ralston Wells of Daytona Beach, vice-president of the Association, spoke briefly.

The next order of business was the selection of a meeting place for 1939. An invitation to meet at Sanford with the Seminole County Medical Society was presented by Dr. Thomas F. McDaniel of Sanford. A vote was taken and Sanford was unanimously selected. After announcements by Dr. W. L. Ashton of Umatilla, a short recess was taken.

The scientific session was called to order by Dr. W. C. Page of Cocoa, at the official time set on the program, 4:30 p. m. The first essayist was Dr. L. L. Whiddon of Ft. Pierce, who read a paper on "Practical Odds and Ends." The second paper was by Dr. William O. Fowler of Orlando, on "Artificial Pneumothorax, Its Technique, Value and Usage." The third paper, by Dr. T. C. Kenaston of Cocoa, was entitled "Coronary Thrombosis in General Practice." Dr. T. M. Rivers of Kissimmee presented the fourth paper, on "The Relation of the Sympathetic Nervous System to Health and Longevity." The papers were well presented and drew interested discussion from the listeners.

Doctor W. Henry Spiers, the Association's president, was unavoidably late in arriving at Eustis, and he was heard at the close of the scientific session, instead of at the time scheduled on the program. Doctor Spiers reviewed the legislative program and other matters of interest in the activities of the Association throughout the state.

#### REGISTRATION—DISTRICT E

*Officers:* W. C. Page, Cocoa, Junior Counselor; Stewart Thompson, Jacksonville, Managing Director.

*Apopka:* T. E. McBride. *Clermont:* E. M. Coleman. *Cocoa:* T. C. Kenaston. *Daytona Beach:* J. Ralston Wells.

*Eustis:* L. R. Bowen, M. M. Hannum, C. M. Tyre, R. H. Williams. *Fort Lauderdale:* Leigh F. Robinson. *Fort Pierce:* F. A. Gowdy, A. M. Sample, L. L. Whiddon.

*Groveland:* W. G. DeVane. *Jacksonville:* Edward Jelks, Shaler Richardson. *Kissimmee:* T. M. Rivers. *Lakeland:* Herman Watson. *Leesburg:* Clyde F. Bowie, Leroy Oetjen.

*Melbourne:* I. M. Hay. *Mount Dora:* H. T. Fenn, Will L. Wood. *Ocala:* Eugene G. Peek, E. Lawrence Scott.

*Orlando:* H. M. Beardall, Russell B. Carson, J. R. Chappell, W. O. Fowler, Frank H. Harms, Hewitt Johnston, Duncan McEwan, John S. McEwan, Meredith Mallory, W. S. Mitchell, Louis M. Orr, Gilbert S. Osincup, Don C. Robertson, W. Henry Spiers.

*Sanford:* J. T. Denton, Wade H. Garner, T. F. McDaniel, C. M. Mitchell. *Stuart:* V. W. Burns, J. D. Parker. *Tavares:* Terry Bird, S. C. Colley, Oliver Emerson. *Umatilla:* W. L. Ashton. *Winter Park:* Arthur McGugan.

*VISITORS—Eustis:* C. J. Reilly. *Orlando:* Gerhard A. Brecher. *Birmingham, Ala.:* S. Ralph Terhune. *Atlanta, Ga.:* William P. Nicolson.

*WOMAN'S AUXILIARY—Eustis:* Mrs. L. R. Bowen, Mrs. M. M. Hannum, Mrs. C. J. Reilly, Mrs. J. L. Roby, Mrs. C. M. Tyre. *Fort Lauderdale:* Mrs. Leigh F. Robinson. *Groveland:* Mrs. W. G. DeVane.

*Kissimmee:* Mrs. T. M. Rivers. *Leesburg:* Mrs. L. H. Oetjen. *Mount Dora:* Mrs. Will L. Wood. *Orlando:* Mrs. W. O. Fowler, Mrs. L. C. Ingram, Mrs. J. A. Pines. *Tavares:* Mrs. S. C. Colley. *Umatilla:* Mrs. W. L. Ashton.

## STATE NEWS ITEMS

The regular quarterly meeting of the Florida Society of Dermatology and Syphilology was held at the Duval County Hospital, Jacksonville, Sunday, November 20.

After an interesting clinic and discussion of cases, Dr. Phillip Nippert of Atlanta showed some interesting color lantern slides of various dermatoses. Dr. J. L. Kirby-Smith was chairman of the scientific meeting. President Chadbourne Andrews took charge of the business meeting, and officers for the ensuing year were elected. Dr. Elmo D. French was elected president, and Dr. Lauren M. Sompayrac was re-elected secretary. The next meeting is to be held in Tampa in the spring.

Guests of the Society were Drs. Rothwell Lefholz of Miami, Francis Copp of Jacksonville, Phillip Nippert of Atlanta and Horace B. Frost of Chicago.

\* \* \*

Dr. and Mrs. P. H. Guinand of Clearwater returned November 5 from a five-weeks cruise to Caribbean and South American ports.

\* \* \*

Dr. Albert C. Kirk of Sanford was recently named full-time physician for the City of Orlando. He succeeds Dr. Claude Anderson, who has been serving as part-time City Physician.

\* \* \*

Dr. M. W. Spearman of Lake City announces the removal of his office to the corner of Columbia and DeSoto Streets, on the ground floor.

## LAKE COUNTY MEDICAL CENTER

The Lake County Medical Center at Eustis, owned and operated by members of the Lake County Medical Society, was formally opened on Sunday, November 6. Although in operation since July 1, the opening was delayed until northern friends had the opportunity to visit and acquaint themselves more thoroughly with this splendid institution.

An interesting program featured the event. Among the speakers were: Dr. W. Henry Spiers of Orlando, president of the Florida Medical Association; Senators C. O. Andrews and Claude Pepper; and Mayor Gaylord of Eustis.

Lake County can well be proud of this hospital, which began in Umatilla in 1933 with only 12 beds and skeleton equipment. With the cooperation of the citizens of the county and many friends from the North, the institution has grown with mushroom rapidity to its present 50 beds. The surgical, obstetrical, laboratory, dietary and general divisions of the hospital are said to be as modern and well equipped as any hospital of its size in the United States. It has the recognition of the American Medical Association, the American College of Surgeons and the American Hospital Association.

The Medical Center is now housed in a section of the Fountain Inn Building, which has been completely renovated and remodeled. This new home was made possible through the very generous gift of the late Frank D. Waterman who donated \$145,000 worth of bonds on the Fountain Inn building to the Lake County Medical Center, consisting of ten stockholders, all members of the Lake County Medical Society. The building occupies an entire block in the heart of the Eustis business section. It was erected in 1922 at a cost of \$450,000. The four-story building contained furniture and fixtures valued at approximately \$50,000. The 165 rooms were all furnished and, besides a number of baths, there were elevators, a large dining room, kitchen, lounge and landscaped approach.

On the first floor of the structure provision is made for 18 stores, most of which are already rented to various business firms. The rent from these concessions goes to the Lake County Medical Center which is to be operated on the sanatorium plan, with one wing for surgical cases and the balance for medical



cases. The doctors of the Lake County Medical Society are justly proud of their new possession and have already made splendid headway in furnishing and equipping this huge building for the care of the sick.

\* \* \*

Dr. and Mrs. W. H. McCullagh of Jacksonville announce the birth of a son, William Henry, on November 12.

\* \* \*

Dr. Paul H. Martin of Jacksonville will be associated with Dr. F. L. Fort and Dr. J. F. Lovejoy, with offices in the Medical Arts Building. Doctor Martin has resumed practice in Jacksonville after two years of specializing in bone and joint surgery in Memphis, Tenn. He will confine his work to this specialty.

\* \* \*

Florida doctors who attended the Thirty-second Annual Session of the Southern Medical Association in Oklahoma City in November are as follows: W. P. Adamson and C. A. Andrews, Tampa; James L. Borland, Jacksonville; Herbert L. Bryans, Pensacola; Joseph L. Chilli, Jacksonville; Elmo D. French, Miami; Gordon H. Ira, John F. Lovejoy, J. G. Lyerly, and A. B. McCreary, Jacksonville; Louis M. Orr, II, Orlando; Naboth O. Pearce, Miami Beach; J. H. Pierpont, Pensacola; J. E. Rose, Crescent City; H. Mason Smith, Tampa; W. Henry Spiers, Orlando; and Frank M. Woods, Miami.

\* \* \*

Dr. Lucien Y. Dyrenforth of Jacksonville was recently made chairman of the Committee on the Biological Sciences, Florida Academy of Sciences, at the meeting at Winter Park.

\* \* \*

Dr. J. R. Jeffrey of Miami Springs, returned recently from a five-months' trip. He spent two weeks at Mayo Clinic, Rochester, six weeks at Cook County Hospital, Chicago, and three months at Battle Creek, Mich.

\* \* \*

Dr. Marion B. O'Kelley of Leesburg and Miss Barbara Davis Hoffman of Washington, D. C., were married on November 4.

\* \* \*

Dr. and Mrs. Don C. Robertson of Orlando announce the birth of a daughter, Dorothy Louise, on July 21, 1938, in Orange General Hospital.

Dr. and Mrs. W. S. Mitchell of Orlando announce the birth of a daughter, Florence Gay, on November 2.

\* \* \*

Dr. M. B. Marks of Miami Beach was delegate from the University of Illinois College of Medicine at the impressive installation of the University of Florida Chapter of the honorary scientific society of Sigma Xi at Gainesville on October 28.

\* \* \*

The series of weekly radio programs by the American Medical Association and the National Broadcasting Company began Wednesday, October 19, and will run consecutively for thirty-six weeks. The program is broadcast over the Blue network of the National Broadcasting Company each Wednesday at 2 p. m., e. s. t. Beginning with the New Year, the dramas will deal for four weeks with the general subject "Dodging Contagious Diseases." The weekly topics will be "Only a Cold!"; "Scarlet Fever, Measles, and Whooping Cough"; "Smallpox and Diphtheria"; and "Preventing Epidemics."

\* \* \*

#### FLORIDA CRIPPLED CHILDREN'S COMMISSION SEEKS MEDICAL DIRECTOR

The services of an executive medical director are being sought by the Florida Crippled Children's Commission. He must have had two years' experience in public health work or two years in pediatrics. The salary will be \$4,200 annually, plus adequate traveling expenses. Interested physicians should file their applications by December 15 with Mr. James Messer, Sr., Chairman of the Florida Crippled Children's Commission, Tallahassee, Florida.

\* \* \*

Dr. Edward Jelks of Jacksonville was elected chairman of the Technical Advisory Committee to the Florida Crippled Children's Commission at a meeting held in Jacksonville, December 1.

Other physicians on the Technical Advisory Committee are Dr. T. H. Bates, Lake City; Dr. Herbert L. Bryans, Pensacola; Dr. R. H. Knowlton, St. Petersburg; Dr. Warren Quilian, Coral Gables; Dr. W. Henry Spiers, Orlando; ex officio member, Dr. F. L. Fort, Jacksonville. Two doctors are members of the Florida Crippled Children's Commission: Dr. S. C. Colley, Tavares, and Dr. Eugene G. Peek, Ocala. These two doctors are also ex-officio members of the Technical Advisory Committee.



## COMPONENT COUNTY SOCIETIES

### ESCAMBIA COUNTY MEDICAL SOCIETY

The Escambia County Medical Society, with a membership of 44, has reported 100% of 1938 dues. Congratulations!

\* \* \*

### MADISON COUNTY MEDICAL SOCIETY

The Madison County Medical Society is on the Honor Roll of 100% paid societies. It is the twentieth society to gain this distinction.

\* \* \*

### PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. H. L. Harrell entertained the Pasco-Hernando-Citrus County Medical Society at Dade City, Thursday evening, November 10. A roast chicken dinner was served at the Edwinola Hotel, followed by a scientific meeting at the hotel.

Dr. Charles L. Farrington of Tampa read an interesting paper on fractures of the forearm, describing treatment. Clinical cases were reported by those present.

A committee consisting of Doctors Jones, Harrell and Bradshaw was appointed to draft a new constitution and by-laws for the society. Doctor Manley of Zephyrhills invited the Society to hold its next meeting with him in Zephyrhills, December 8.

Those present were Doctors Bradshaw, Carter, Creekmore, Harrell, Harvard, Jones, Manley, Sistrunk, Walters and the invited guest, Doctor Farrington.

\* \* \*

### PINELLAS COUNTY MEDICAL SOCIETY

The Annual Dinner of the Pinellas County Medical Society was held at the Veterans' Hospital, Bay Pines, November 4, at 6:30 p. m. Members of the Hillsborough County Medical Society and the Nurses Association were invited to attend this function.

\* \* \*

### SARASOTA COUNTY MEDICAL SOCIETY

The Sarasota County Medical Society stands 100% paid for 1938. This society has a membership of 15.

## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

### Artificial Fever Therapy in Skin Disorders:

**Clinical and Biochemical Studies with Special Reference to the Physiology Involved—LITTERER, A. BUIST, and PHILLIPS, KENNETH, Miami. *South. M. J.* 31:345-355 (Apr.), 1938.**

One hundred and sixty-seven patients with cutaneous diseases have been studied for four years in regard to the response to fever therapy of such entities as eczematoid lesions (allergic or non-allergic), erythema multiforme, psoriasis, endocrinopathies with skin manifestations, urticaria, seborrheic dermatitis, etc.

Response to fever therapy in the eczematoid group is immediate in ninety-six per cent and continues into the fourth month. By the fourth year there has been relapse in thirty-one per cent of those who received a complete clinical remission. In the multiforme cases ninety per cent receive complete resolution which is maintained well into the fifth month, but after two years there is a relapse of about thirty-three per cent. In psoriasis there is a fifty per cent immediate response which will show thirty-three and a third per cent relapse in four years. In the endocrine group the immediate response to fever therapy shows about eighty per cent cured and over four years these remain so. In urticaria only sixty-two and a half per cent gain an immediate response and sixty per cent of these will relapse, but if the underlying gastro-intestinal, biliary, or endocrinological factors are treated at the same time, the immediate response is seen in eighty-five per cent with about a twenty-five per cent relapse. These figures are better than those seen with other forms of treatment so that the authors are highly encouraged to continue and extend these studies.

By study of the composition of the sweat and its crystals the authors are led to suggest that there is a common underlying toxic or metabolic disturbance in these usually resistant dermatoses. Due to the action of fever

therapy in producing increased metabolism, increased circulation and oxidation, and increased elimination through the skin, these underlying toxic and metabolic disturbances are altered and the patient is benefited.

Because the skin normally functions at a lower temperature than the body internally, the apparatus used in fever therapy must be one which will preserve this physiological gradient. Therefore, penetrating heat is preferable to external heat as in baking. But a particular type of penetrating heat is necessary; the use of contact points or electrodes on an already abnormal skin is undesirable, and the apparatus used must have a proper frequency so that the danger of arc formation with the pools of sweat formed is obviated. The inductotherm combined with the air-conditioned cabinet will overcome both of these difficulties which cannot be so easily minimized if the ordinary diathermy is used.

**Chilling of the Body Surfaces. Its Relationship to Aural and Sinus Infections—TAYLOR, H. MARSHALL, and DYRENFORTH, LUCIEN Y., Jacksonville, J. A. M. A. 111: 1744-1747 (Nov. 5), 1938.**

Any considerable deviation in the human body from a constant average temperature, maintained for appreciable lengths of time, will result in morbid changes. Cold water, because it absorbs body heat 27 times faster than does air, is a medium which is capable of throwing the heat regulating mechanism out of its normal controlling action and allows for lowering the immune barriers of the normally constituted aural and sinus mucosae, so that these centers may suffer infection. The immediate practical application indicated is the harmfulness of immoderate immersion and exposure such as bathing, swimming or chilling influences of many kinds. Experiments were made which indicate that during exposure peripheral vasoconstriction, which is a factor in the establishment of infection, is prevented by muscular activity. Animals exposed to chilling influences without exercise developed uniformly a leukopenia of the polymorphonuclear type, indicating a diminution of the phagocytic powers of the blood. A coincidental lowering of body temperatures accompanied this feature. A series of similar tests conducted upon non-exercising human



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bathers demonstrated similar responses. On the other hand, when such individuals were exercising (marathon swimming) there was a decided increase in the total leukocyte count, with a concomitant rise in the erythrocytes and in the diastolic blood pressure. Such impairment of the phagocytic capabilities of the blood and the fixed tissue cells, including that of the nasal mucous membrane, may result in predisposition to infections of the upper respiratory tract, the paranasal sinuses, the eustachian tubes and the middle ear.

**Ptosed Spleen with Torsion of Pedicle—ADKINS, ELMER H., Miami Beach. *Ann. Surg.*, 107:832-835 (May), 1938.**

The author reports an interesting case of ptosed spleen with torsion of its pedicle.

The patient, a male, 25 years of age, was suddenly seized with acute abdominal pain following the lifting of a heavy table. Examination revealed a palpable mass in the left lower abdominal quadrant with marked abdominal tenderness and rigidity. Roentgenograms with barium revealed a fair sized diverticulum in the upper portion of the descending colon and a provisional diagnosis of diverticulum of the sigmoid flexure with slow perforation was made.

At operation a markedly enlarged and engorged spleen and pedicle were found, the latter showing a  $\frac{1}{2}$  to  $\frac{3}{4}$  twist. Splenectomy was performed and the vessels of the pedicle were ligated individually.

Postoperative recovery was stormy due to marked abdominal distention, accumulation of fluids in the stomach and thrombosis of the right femoral vein.

Splenoptosis may be of congenital or acquired origin. In the former, the length of the pedicle and conformation of the abdominal cavity are the important factors. In the latter, weight of the spleen and factors influencing relaxation of the abdominal wall are of importance. Increased mobility of the organ through lengthening of the pedicle naturally contributes to the possibility of torsion and consequent interference with the vascular supply and drainage.



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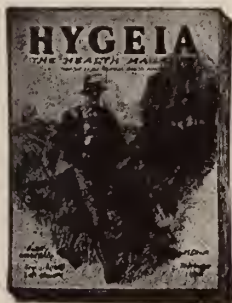
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## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**MEDICINE IN MODERN SOCIETY.** By DAVID RIESMAN, M.D., Prof. of History of Medicine, and Prof. Emeritus of Clinical Medicine, U. of Pa.; President American Society of Medical History.

This book grew out of the author's belief that "the history of medicine is in reality an epitome of the history of civilization and should form a part of every man's culture." It was developed from a series of lectures known as the Vanuxem lectures which the author delivered at Princeton University. Cloth, pp. 226; price, \$2.50. Princeton, N. J.: Princeton University Press.

**DOCTORS, I SALUTE!** By EMILIE CONKLIN, author and poet. As far as known, this is the only book of verse ever dedicated to "The Healers of the World; those whose lives are dedicated to the relief of pain and distress." The author's background of many years' experience as a medical social worker has given her an understanding of the trials and triumphs of a physician, which she has delightfully woven into her poems. Cloth, pp. 92. Winona Lake, Ind.: Light and Life Press.

A "TENTATIVE EDITION OF DIAGNOSTIC STANDARDS," for tuberculosis of the lungs, has just been issued in pamphlet form by the National Tuberculosis Association through its Committee on Diagnostic Standards, and headed by Dr. Fred H. Heise, medical director of Trudeau Sanatorium, Saranac Lake, N. Y.

Both primary and reinfection tuberculosis are described under the heading, "Pathogenic Development of Pulmonary Tuberculosis."

"It is not always possible on clinical and roentgenological evidence to differentiate primary and reinfection tuberculosis," says the committee. "It is important, however, to recognize the pathogenic phase in which a given lesion presents itself, since such knowledge is, within strict limitations, the safest available prognostic criterion."

The committee deals with the clinical course of tuberculosis correlated with pathological conceptions. It continues: "The early pulmonary infiltration, the most common early lesion of reinfection, and the precursor of most of the chronic and fatal tuberculosis in adults may appear at any age, but most frequently between eighteen and thirty or thirty-five (in Negroes, a few years earlier). The onset may be symptomless, devoid of abnormal physical signs, and denoted only by the appearance in the roentgenogram of a soft mottled or cloudy patch. Symptoms, when present, are constitutional—mainly fatigue, loss of energy and a small loss of weight; when more severe, they suggest grippe and the lesion may resemble grippal pneumonia."

Failure to find tubercle bacilli in the sputum does not rule out cavity, the report states. Excavation usually is the beginning of progressive pulmonary tuberculosis and prevention or closure of the cavity is the most important single feature of clinical recovery. Otherwise, contamination of other parts is inevitable.

The tuberculin test, x-ray evidence, the history of exposure, symptoms and clinical manifestations, physical signs and laboratory methods are included under the section, "Diagnosis of Tuberculosis." Constitutional and local symptoms are explained in detail. The extent of pulmonary lesions is explained in a descriptive summary, as are observations bearing on cases considered arrested, quiescent, etc.

A copy of the booklet, "Diagnostic Standards," may be obtained without cost from the Florida Tuberculosis and Health Association, 111 W. Ashley Street, Jacksonville.



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"Delsterol" is indicated wherever it is desired to administer Vitamin D for prophylaxis or therapy, as to premature infants, in the prevention and cure of rickets, for expectant and nursing mothers, and in disorders of calcium-phosphorus metabolism where there is a deficiency of Vitamin D. The daily prophylactic dose for the average infant is 5 drops (approximately 0.1 cc.) which supply 850 units of Vitamin D. For premature infants the daily dose is 15 drops; during pregnancy and lactation and in treatment of rickets, the daily dose is 20 drops or more, as may be indicated.

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Furthermore, at this season, the mother is likely to bundle her baby to keep it warm, shutting out the sun from Baby's skin; and in turning the carriage away from the wind, she may also turn the child's face away from the sun.

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quirement of the human adult for vitamin D is still not known (3). The International system of expressing vitamin D potency has been universally adopted; bioassay methods have been standardized (4); and last but not least, a high degree of standardization has been attained, not only in regard to the antirachitic potency of Vitamin D preparations, but also as to the extent to which the vitamin D contents of certain foods should be increased by the various means available (3).

While some foods, including some canned foods of marine origin, are valuable food sources of vitamin D (5), no combination of common foods—as they occur naturally—can supply the demands of the infant and child for the antirachitic factor. Although there is no reason as yet to believe that the normal adult requirement for vitamin D is not largely fulfilled by a varied diet of protective foods, it is definitely known that the infant and child dietaries must be supplemented with or fortified by vitamin D.

It is in the formulation of basic diets for either infants or adults that commercially canned foods should prove especially valuable. Among the great variety of American canned foods are included special foods for use in child and infant feeding which, when properly supplemented or fortified, should meet the nutritive demands of those stages of life. For the normal human adult—whose diet hardly requires special supplementation—there are a large number of canned foods available which readily permit formulation of a varied diet of the so-called protective foods.

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(1) 1932. J. Amer. Med. Assn. 99, 215 and 301.

(2) J. Amer. Med. Assn. 110, 2150.

(3) Ibid. 110, 703 and 1179.

(4) 1936. U. S. Pharmacopeia, XI Decennial Revision.

(5) 1935. J. Home Econ. 27, 658.

1933. Science 78, 368.

*We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-third in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.*



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## STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	W. Henry Spiers, Orlando	Shaler Richardson, Jacksonville	Daytona Beach, May 1, 2, 3, 1939
Florida Medical Districts:			
A—Northwest	N. A. Baltzell, Marianna	Stewart Thompson, Jacksonville	Marianna, 1939
B—North Central	R. B. Harkness, Lake City	" " "	Ocala, 1939
C—Northeast	W. McL. Shaw, Jacksonville	" " "	Palatka, 1939
D—Southwest	J. W. Alsobrook, Plant City	" " "	Lakeland, 1939
E—South Central	H. D. Clark, Ft. Pierce	" " "	Sanford, 1939
F—Southeast	H. A. Walker, Miami Beach	" " "	West Palm Beach, 1939
Alabama Medical Association	Seale Harris, Montgomery	D. L. Cannon, Montgomery	Montgomery, Apr. 18-20, 1939
Georgia Medical Association	Grady N. Coker, Canton	E. D. Shanks, Atlanta	Atlanta, May 9-12, 1939
Florida—			
State Dental Association	R. P. Taylor, Jacksonville	E. C. Lunsford, Miami	West Palm Beach, 1939
Soc. of Derm. and Syph.	Elmo D. French, Miami	Lauren Sompayrac, Jacksonville	Tampa, 1939
East Coast Medical Association	Fredrick J. Waas, Jacksonville	A. J. Logie, Jacksonville	Jacksonville, 1939
State Hospital Association	Gertrude Overstreet, Gainesville	Mr. Fred Walker, Jacksonville	Jacksonville, Apr. 13-15, 1939
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
State Nurses Association	Mrs. Inez Nelson, Orlando	Mrs. Phyllis Leonard, St. Augustine	Lakeland, 1939
Pediatric Society	Gilbert S. Osincup, Orlando	Warren Quillian, Coral Gables	Daytona Beach, 1939
Pharmaceutical Association	Mr. R. Q. Richards, Ft. Myers	Mr. A. W. Morrison, Miami	Hollywood Beach, May, 1939
Public Health Association	A. B. McCreary, Jacksonville	E. M. L'Engle, Jacksonville	Jacksonville, 1939
Radiological Society	H. O. Brown, Tampa	J. H. Lucinian, Miami	Daytona Beach, 1939
Railway Surgeons Association	Herman Watson, Lakeland	H. D. Clark, Ft. Pierce	Daytona Beach, 1939
Tuberculosis & Health Assn.	Mr. G. E. Therry, W. Palm Beach	Mrs. May Pynchon, Jacksonville	Spring, 1939
Chattahoochee Valley Med. Assn.	J. S. Turberville, Century	Frank K. Boland, Atlanta	Albany, Ga., July 11-13, 1939
Gulf Coast Clinical Society	J. H. Dodson, Mobile	C. C. Rouse, Mobile, Ala.	Mobile, 1939
Southeastern Derm. Assn.	J. R. Allison, Columbia	Howard King, Nashville	Nashville, Sept. 3, 1939
Southeastern Surgical Congress	T. C. Davison, Atlanta	B. T. Beasley, Atlanta	Atlanta, Mar. 6-8, 1939
Southern Medical Association	W. E. Vest, Huntington, W. Va.	Mr. C. P. Loran, Birmingham	Memphis, 1939
Suwannee River Medical Society	E. C. Chamberlain, Madison	Eustace Long, Madison	

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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Dis- tricts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not In- cluded in First Column	Members	
						Total	Paid
Northwest District (A) Marianna 1939	Bay	W. J. Blackshaar, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'40 Carol C. Webb, M. D., Pensacola	11	100%
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		44	100%
	Walton-Okealoosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		<i>Santa Rosa</i>	8	100%
	Franklin-Gulf	Chapman Dykes, M.D., Carrabelle	A. L. Ward, M.D., Port St. Joe		A-2-'39 N. A. Baltzell, M. D., Marianna	7	100%
	Jackson	D. A. McClunnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.		16	14
	Leon-Gadsden-Liberty- Wakulla-Jefferson	W. W. Massey, M.D., Quincy	B. A. Wilkinson, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	<i>Calhoun</i>	38	36
North Central District (B) Ocala, 1939	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanche Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	18	16
	Madison	E. Long, M. D., Madison				3	100%
	Taylor	Ralph J. Greena, M.D., Perry	W. J. Baker, M. D., Foley	Last Friday 8:00 P. M.	<i>Baker-Dixie-Hamilton- Lafayette-Suwannee</i>	8	6
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M. D., McIntosh	28	24
	Marion	Carney W. Mimms, M. D., Commercial Bank Bldg., Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	100%
	Pasco-Hernando- Citrus	Samuel C. Harvard, M. D., Brooksville	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		15	100%
	Sumter	Clyde L. Carter, M.D., Wildwood		2nd Tuesday	<i>Bradford-Gilchrist- Levy-Union</i>	4	100%
N. E. District (C) Palm Bay 1939	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	167	157
	St. Johns	J. J. Spancar, M. D., 32 Saragossa St., St. Augustine	Vernon A. Lockwood, M.D., East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	<i>Olay-Nassau</i>	10	100%
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganious, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M. D., Daytona Beach	10	100%
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.		39	38
					<i>Flagler</i>		
Southwest District (D) Lakeland, 1939	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St., Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	107	104
	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		14	100%
	Pinellas	E. C. MacCordy, M.D., 627 11th St., N. St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		90	100%
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		15	100%
	DaSoto-Hardee-High- lands-Charlotta-Gladas	L. W. Martin, M.D., Sebring	Howard V. Weems, M.D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M. D., Lakeland	21	19
	Lee	H. Quillian Jonas, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	12
	Polk	W. W. Shafer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	<i>Collier-Hendry</i>	66	58
South Central District (E) Sanford, 1939	Bravard	G. E. Christia, M.D., Titusville	I. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M. D., Cocoa	12	100%
	Lake	Harry T. Fenn, M. D., Mount Dora	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		18	100%
	Orange	H. A. Day, M.D., 209 Exchange Bldg., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		73	100%
	Seminole	J. N. Tolar, M. D., Sanford	Douglass G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	<i>Osceola</i>	13	100%
	St. Lucie-Okeechobee- Indian River-Martin	R. C. Boothe, M.D., Ft. Pierce	Adrian M. Sample, M.D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	16	100%
S. E. District (F) W. Palm Beach, 1939	Broward	A. B. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M. D., West Palm Beach	31	100%
	Palm Beach	V. M. Johnson, M.D., Good Samaritan Hospital, W. Palm Beach	J. R. Sory, M.D., 616 Harvey Bldg., West Palm Beach	4th Monday 8:00 P. M.		58	100%
	Dade	Arthur H. Welland, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzer, M. D., 803 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	285	279
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	100%



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# The JOURNAL

of the

## Florida Medical Association, Inc.

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VOLUME XXV  
No. 7

Jacksonville, Florida, January, 1939

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#### NEXT SESSIONS

American Medical Association, St. Louis, May 15-19, 1939  
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Southern Medical Association, Memphis, November, 1939

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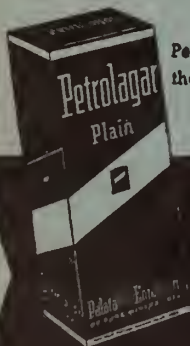
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## RECENT ADVANCES IN THE SCIENCE OF NUTRITION

### V. Factors Affecting the Vitamin C Contents of Foods

● Recent development of the chemical method for estimation of ascorbic acid (1) has permitted more thorough study of factors determining the vitamin C contents of foods. Circumspectly used, the 2, 6 dichlorophenol-indophenol or "indicator" titration method for vitamin C determination has proven an invaluable tool in this phase of research.

It is now apparent that the vitamin C content of food at the time of consumption is conditioned, first, by the initial ascorbic acid content of the food at the time of harvesting, and second, by the treatment to which the food is subjected between the time of harvesting and the time of consumption.

The initial vitamin C level in raw foods has been found to depend on factors such as variety, maturity and growing conditions (2). Under usual conditions of food crop production, such factors are only partially subject to human control. However, the factors influencing vitamin C in foods from harvesting until consumption are capable of closer regulation by man.

For example, it is known that long storage at improper temperatures adversely affects the initial ascorbic acid contents of foods. Even at refrigeration temperatures raw foods may lose substantial amounts of vitamin C during storage. Rough handling—which causes rupture of vegetable tissue—is also conducive to vitamin C loss especially when followed by improper storage. Certain metals will catalyze vitamin C destruction and even commonly used home-

cooking methods are attended by losses of this essential dietary factor (2).

Briefly, preservation of vitamin C in foods between harvesting and consumption is essentially a problem of preventing or reducing oxidation, either enzymatic or atmospheric. In addition, physical or solution losses must be minimized in preparation of the food for the table. It is pertinent to note that modern commercial canning procedures are well adapted to control both these chemical and physical losses of vitamin C (3).

The use of prime raw stock and quick transport to the cannery after harvesting; rapid inactivation of enzymes through heat treatment; and large scale automatic operations with minimal exposure to air, are basic practices common to all modern canning procedures. All serve to check oxidative losses of the initial ascorbic acid present in raw foods. In addition, during canning, the foods are cooked by the heat process while contained in the sealed can. The liquid within the can, therefore, retains vitamin C which has been removed from the food by solution.

Researches have shown that many commercially canned foods are to be listed among the most valuable contributors of vitamin C to the diet of the American people (2, 3, 4). Such findings demonstrate the effectiveness of modern commercial canning procedures in preservation to the highest practical degree of the initial vitamin C contents of foods.

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(1) 1932. Ztschr. f. Untersuch. d. Lebensmitt. 63, 1.

1933. J. Biol. Chem. 103, 687.

(2) 1938. J. Amer. Med. Assn. 111, 1290.

(3) 1932. Ind. Eng. Chem. 24, 650.

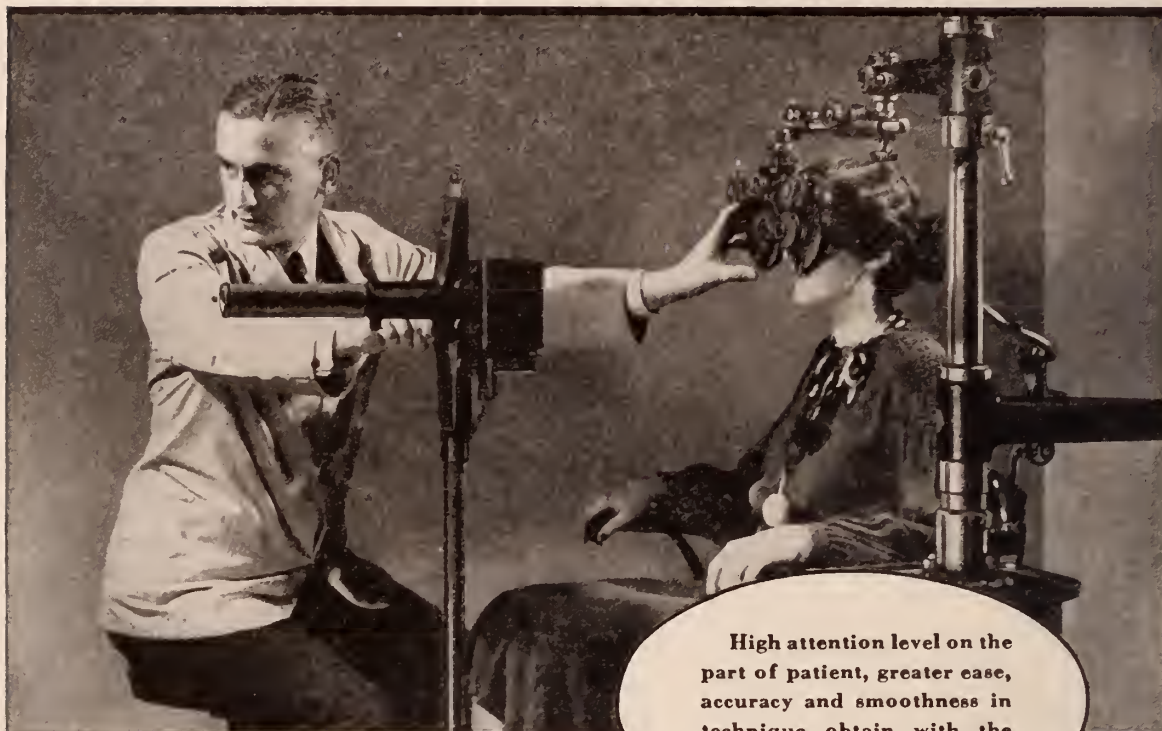
(4) 1938. J. Amer. Med. Assn. 110, 650.

1937. Bull. 19-L Nat'l. Canners Assn., Washington, D. C., 4th Ed.

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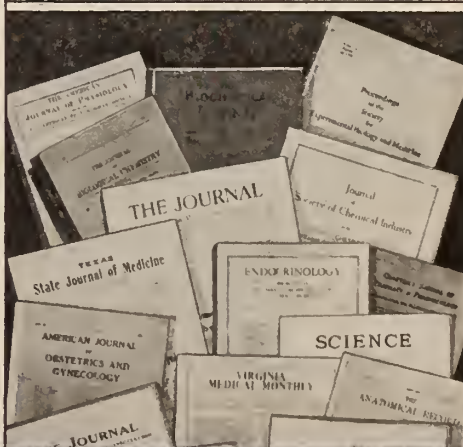
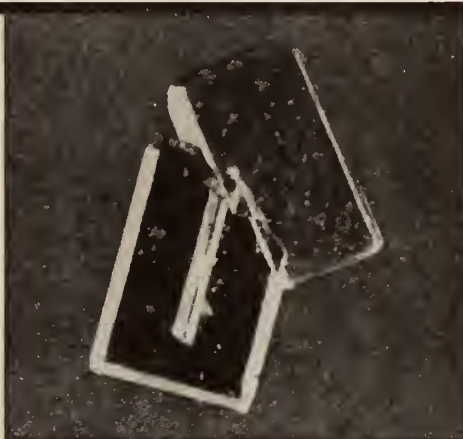
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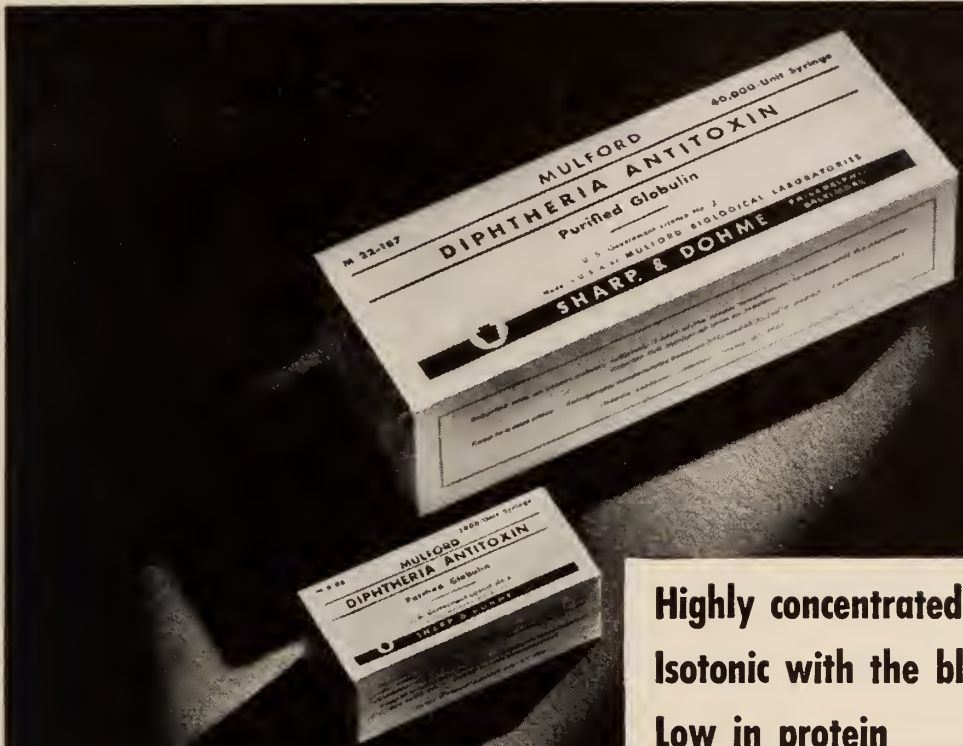
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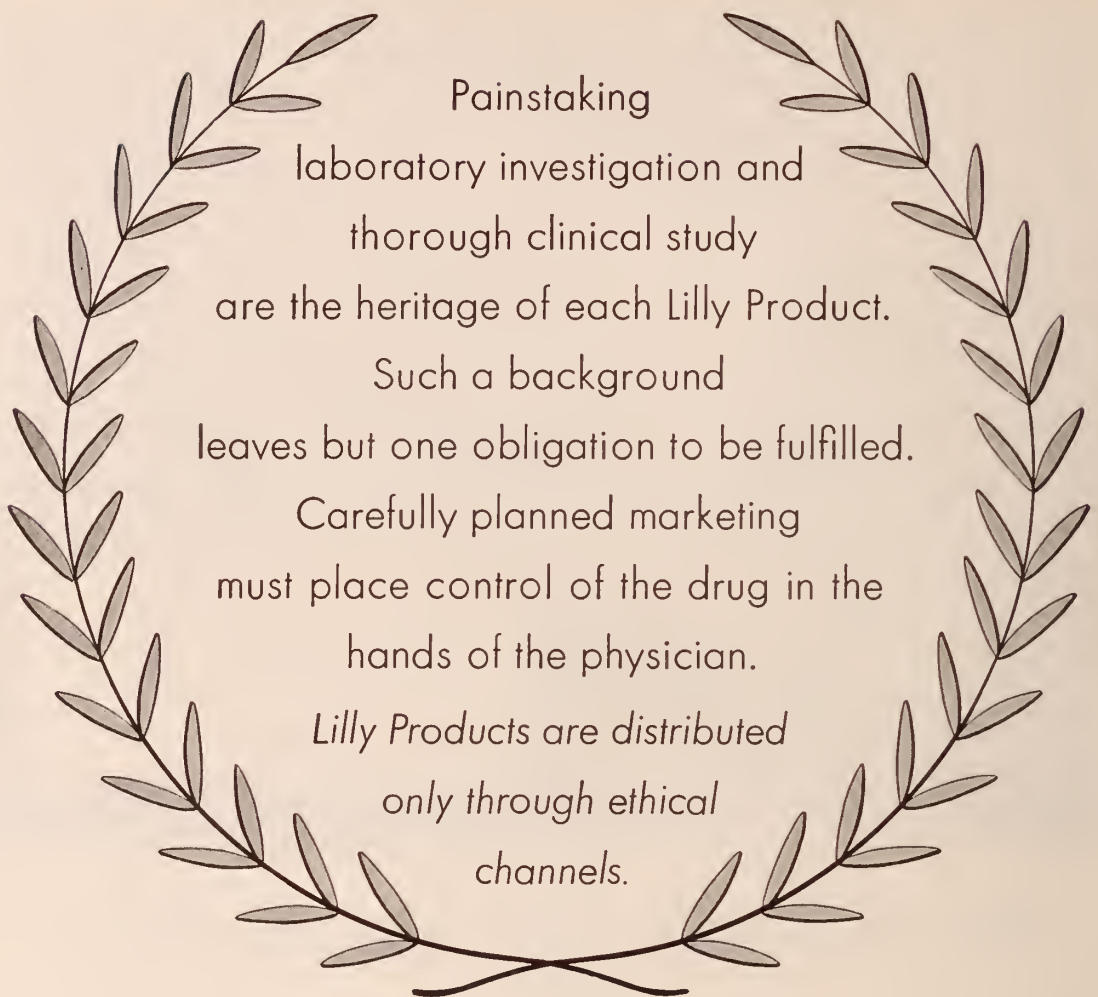
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## PRESACRAL NERVE RESECTION FOR RELIEF OF PELVIC PAIN

JOHN R. BOLING, M. D.,  
Tampa.

Although resection of the presacral hypogastric plexor has been, for many years, known to give relief of pelvic pain, it is only within the past ten years that it has come into even moderate use. The men in European countries have made far greater use of this highly satisfactory procedure than those in this country. Jaboulay<sup>1</sup> in 1898 was the first to report such a resection. He resected the coccyx and approached the plexus through the perineum. About one year later, Ruggi<sup>2</sup> resected the plexus by the transperitoneal route. In 1924 Cotte<sup>3</sup> published his technique and following this, much work has been done. Especially in the last few years has the importance of this operation been recognized in this country.

The presacral plexus lies in the angle formed by the bifurcation of the abdominal into the common iliac arteries. This is a sympathetic plexus formed by nerves from the inferior mesenteric ganglia and from nerves of the first and fourth lumbar ganglia. The plexus begins about one inch below the inferior mesenteric artery and enters the pelvis at the bifurcation of the aorta where it is most accessible. The plexus usually consists of numerous small nerves and lies posteriorly to the peritoneum in the fatty tissue between the arteries. In about 15 per cent of cases it is a single nerve. In either type it is usually over toward the left iliac vessel. After passing over the promontory of the sacrum, the nerve forms the right and left hypogastric plexuses. The plexuses have to do with vascularity of the pelvis as they are vasoconstrictors. Fontaine and Herrmann<sup>4</sup> believe that the hypogastric plexus carries the nerve pathways of sensation to the brain and that section prevents the passage of pain sensations.

The indications for this operation can be grouped under the head of pelvic pain, bladder

and lower gut dysfunction. In dysmenorrhea, more especially of the functional type, it is of inestimable value. At first thought this may seem a rather radical procedure for pain occurring in an apparently normal pelvis. However, when one considers that many women are partially or completely incapacitated for three to six days each month, which adds up to one or two months out of every year, the operation is a godsend to them. Resection is also indicated in dysmenorrhea due to pathology that cannot wisely be removed. I think it wise in those cases of pelvic inflammation in which radical surgery is not indicated, to do a presacral resection along with other corrective surgery in the pelvis. I am sure that in the past we have all removed tubes and left involved ovaries knowing that the patient would have menstrual pain but feeling that this would be better than the symptoms following complete operation.

In this type, a nerve resection is of great aid. Certainly no functional dysmenorrhea should be operated upon until other valuable and simpler methods are tried. After one has exhausted every means to relieve these patients, there will still be many whom only operation will benefit. Pain from inoperable cancer of the uterus and cervix can be controlled by this method. Dr. John E. Cannaday<sup>5</sup> reported 78 cases with followup. In this group, 45 had complete relief, 83 per cent were improved. The group ranged from simple dysmenorrhea of functional type to inoperable cancer of the uterus. Dr. Frederick S. Wetherell<sup>6</sup> reported 7 cases of dysmenorrhea in all of which he obtained good results. Abbott reported relief in cord bladder not due to syphilis and in bladder paralysis. He also reported relief from obstinate constipation by resection of the presacral nerve. One sees more and more frequently articles of this type showing excellent results.

### TECHNIQUE

The operation is readily done through a low median incision. I find that extending the incision to the left and an inch above the navel makes exposure easier. The intestines are then well walled off with packs, complete relaxa-

Read before the Sixty-fifth Annual Meeting of the Florida Medical Association, held in Miami, May 9, 10, and 11, 1938.



tion being necessary for this to be done. The posterior peritoneum is opened and the entire interiliac angle exposed. I have found that the injection into the interiliac region of 3 or 4 cc. of saline in which a few minims of adrenalin solution has been added, makes the operation drier and visualization of the plexus easier. Although the bleeding should never be great, it is wise to do the dissection in as clear a field as possible because of the territory in which one is working. Care is needed to prevent injury to the iliac vessels which might prove, at least, embarrassing. Some authors advise removal of the plexus from above down but I feel that it is somewhat easier to begin over the region of the right iliac and pick up the fibers of the plexus along with the loose connective tissue and continue along the posterior wall of the angle on over the anterior surface of the left iliac. As the tissue is picked up and held in the grasp of an Allis forceps, the entire mass is dissected up to the aorta, cut and tied. I feel it is safer to tie both ends because some small vessels are often in the mass. To prevent formation of neuroma, alcohol is injected in the upper stump. Following this the peritoneum is closed.

In thin women the operation is comparatively easy and the structures readily made out. In fat women the operation may be quite difficult. The nerve or plexus cannot be easily identified and it is necessary to do a complete block dissection between the vessels, great care being taken not to injure any of the large vessels. In one of my cases, the right ureter crossed the iliac quite high up. Whatever pelvic pathology is present should be removed or corrected. Although I believe that dysmenorrhea due to a retroflexion would probably be cured by nerve resection, I think it wise to correct the malposition by some suitable operation along with resection of the nerve.

Convalescence is no different from that following any pelvic operation except that possibly in a larger percentage of cases it is necessary to catheterize for a day or two. My experience has been limited but exceedingly satisfactory. In all but two cases pain at menstruation has ceased, for how long I do not know, as the longest time lapsed since operation is only three years. One patient I have not heard from.

I am going to report four cases that are outstanding not only because of the results obtained but also because two were of the type so often put under the category of neurotics. The third is one in which sufficient pathology was left to have caused pain had not nerve resection been done; the fourth, gut dysfunction.

#### CASE REPORTS

Case I. An unmarried woman, aged 23, was admitted to the hospital December 26, 1935. Since menstruation began she had suffered both during and before the period with severe pelvic pain. During the previous two years the condition had become worse and she was having an associated neurotic tendency. With nearly every menstrual period she would have sudden increased cramping pain and fall over in what she termed an "unconscious state" lasting for a few minutes. The last such seizure occurred while she was riding in an automobile. From the history one would suspect a neurotic young woman that surgery had little to offer in the way of relief, and before the day of presacral nerve resection this would have been true. At operation a normal pelvis was found. A presacral resection and appendectomy was done. The relief has been complete. She menstruates regularly and without pain or nervous symptoms.

Case II. A young woman, aged 20, was admitted to the hospital June, 1936. She went for operation because of repeated attacks of appendicitis. Her history revealed that she suffered with marked dysmenorrhea, the period lasting from 7 to 8 days. She frequently fainted during and immediately following menstruation. Operation showed a diseased appendix and a normal pelvis. Appendectomy and nerve resection were done. Menstruation has been normal and without pain, lasting from 4 to 5 days and she has not fainted since the operation.

Case III. The third case differs from the first two in that there was much pathology in the pelvis. A young woman, aged 22, was admitted to the hospital August 11, 1936, because of pelvic pain. She gave a history of dysmenorrhea for the previous two years. About six months before she had a laparotomy for pelvic abscess by an able surgeon in the middle part of the state. Because of her poor condition nothing was done at the time except drainage of the abscess. She had not been well since, most of her time being spent in bed. Operation revealed a pelvis filled with adhesions, both tubes and ovaries being bound down and against the lateral wall. The left tube was removed and adhesions about the ovaries and right tube freed. Nerve resection was done. She tells me that she has been entirely well since and has gained about 20 pounds.

Case IV. The fourth, a very interesting case, was that of a six year old child with greatly distended abdomen due to obstinate constipation. The patient had been in and out of the hospital for a year, each time returning in an increasingly serious condition,—anemic, marked loss of weight, and enormous abdomen. The constipation would be overcome by repeated enemas and cathartics and the child would return home improved. As time went on the condition gradually became worse necessitating blood transfusions. Diagnosis was indefinite, Hirschsprung's disease of course being thought of but it was not believed to be this. In hope that a sympathectomy might offer help in the constipation the operation was done after transfusion. The convalescence was stormy. Within ten days an uncontrollable diarrhea developed. The pediatric department exerted every effort with diet, etc., but to no

avail. Six weeks later the child developed pneumonia and died. A postmortem was not obtained. How much the nerve resection had to do with the diarrhea, I do not know.

I have handled in all 15 cases, 14 of which were for dysmenorrhea. Followup reports have been had in all but one. Of these 13 cases results have been completely satisfactory in all but two. In one of these the patient was free of pain for one year after which time dysmenorrhea recurred but with less severity than before. In the other there has been little improvement.

#### CONCLUSION

This operation offers relief from pelvic pain that cannot be obtained by any other method.

It lessens the necessity for radical surgery in the presence of pelvic inflammatory disease.

It aids in certain types of bladder and gut dysfunction and relieves pain in hopeless pelvic cancer.

It is a safe procedure and should be without mortality.

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#### DISCUSSION

*Dr. W. M. Rowlett, Tampa:*

I wish to congratulate the essayist upon his splendid paper.

Having done a few resections of the pre-

sacral nerve in the treatment of pelvic pain, especially in obstinate dysmenorrhea, I am convinced of its value as a therapeutic agent for the relief of functional disturbances of the hypogastric plexus. For those patients who are victims of endocrine dysfunctions, losing one or more days every month from their studies or other duties, and where medical or hygienic measures have failed, I feel that presacral nerve resection should be considered.

Due consideration, however, relative to the nervous stability of these patients should be exercised, as any major operation that does not give relief in these introspective individuals widens the chasm between health and invalidism. I find, also, that very little, if any, relief is gotten in those cases of pelvic pain of ovarian origin or intermenstrual pain resulting from ovulation, as the ovary receives its nerve supply from other than the hypogastric plexus. In such complicated cases, a resection of the ovarian nerves is also indicated. The failure of the operation is due to two conditions: first, the incomplete severing of all the nerve fibres; second, an incorrect determination as to the cause of the patient's pelvic discomfort.

Fortunately for most women, menstruation is not accompanied with pain. The delicate autonomic nervous system which regulates menstruation is apparently unaffected by the various stages that make up the menstrual cycle in some women while in others there is a great hypersensitivity which in many instances requires rest in bed and narcotics before relief is obtained. This pain, which is associated with the process of the exfoliation of the endometrium, for many years was attributed to uterine misplacement, cervical stenosis, etc. Treatment by dilation and curettage was a favorite procedure. In many instances the patient experienced some relief. In the face of present-day enlightenment we now realize that the relief was due to stretching of the sympathetic nerve fibers in the cer-



vix and the uterosacral ligaments. A thorough dilation of the sphincter ani probably would have given just as good results.

The advent of the various hormones gave the physicians a ray of hope, but to our sorrow we find that most of them are inadequate in the relief of functional dysmenorrhea. While it has been proved that the estrogenic hormones will stimulate uterine development and that the luteal hormones have an antispasmodic effect on the uterus, the end results have not always been satisfactory.

When the physician will bear in mind that the nerve plexus that supplies the reproductive organs is the most sensitive in the human body and that a very minute infection or abnormality may be the cause of a pelvic neuralgia, then he is going to be more painstaking in his examination and more conservative in his recommendation of treatment. In those cases of functional disturbances of the vago sympathetic nervous system a vicious circle is established, which Adson states is "produced by an abnormal stimuli from the superior autonomic nervous centers of the mid-brain which are connected with the pituitary gland." A presacral sympathectomy, which disconnects the genital organs with the nerve centers in the brain, gives excellent results in relieving these distressing periodical attacks.

*Dr. John R. Boling (concluding):*

I wish to thank Doctor Rowlett for his very able discussion. Again I wish to bring out this fact: any procedure that can relieve a condition that causes complete or partial disability of a person for as much as eight or ten weeks out of each year is well warranted. Nerve resection is of especial value in pelvic inflammatory disease. One dares leave more pathology with the assurance that the resection will prevent pain. At times involved ovaries can be left that otherwise should be removed. In one of the reported cases the pelvis was a mass of adhesion from an inflammatory disease, with marked involvement of both adnexa. One tube was removed and nerve resection done. She has been entirely free of pain since. She conceived but miscarried at 6 or 8 months. Two of these cases have gone through a normal labor.

## SOME OBSERVATIONS ON FRACTURES OF THE HIP

CHARLES B. MABRY, M. D.,  
Jacksonville.

A fracture of the hip occurs when there is a break in continuity of union through the trochanter, through the femoral neck, or when the femoral head is driven by force through the acetabulum into the pelvis. These fractures are extremely disabling because the ability to stand as well as the power of locomotion is at once completely lost. The life of the patient is often in danger because the accident occurs most frequently in the elderly or in the declining years of life when resistance and the will to recover are lessened. The treatment must extend over many weary weeks before the patient may resume anything like his former active life. The various methods of treating these fractures are very well known to you all.

I shall merely touch upon fractures of the acetabulum to illustrate them. (*Fig. 1*). The condition is not an uncommon one. If not reduced there is great probability of a permanent limp or even hip ankylosis. The well leg traction device I will show, gives an excellent reduction. If the pelvis is fractured in both halves the same method can be used but careful attention must be given not to exert too much countertraction.

Fractures through the neck of the femur deserve special attention since non-union is such a frequent occurrence. (*Fig. 2*). The Whitman cast is not used as often as formerly since even the large bone clinics reported about 50 per cent non-union by the method. Mechanical internal fixation has become the method of choice in the majority of orthopedic clinics and the percentage of union has been markedly increased. I have used both the flanged nail (*Figs. 3 and 4*) and the Moore pins for the past several years and in my experience the three Moore pins (*Fig. 5*) have given much more satisfactory results than the flanged nail of Smith-Peterson. I would like to warn that while not a difficult operation to perform, the correct insertion of

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Read before the Tenth Annual Meeting of the Florida East Coast Medical Association, Hollywood, December 13, 1937.



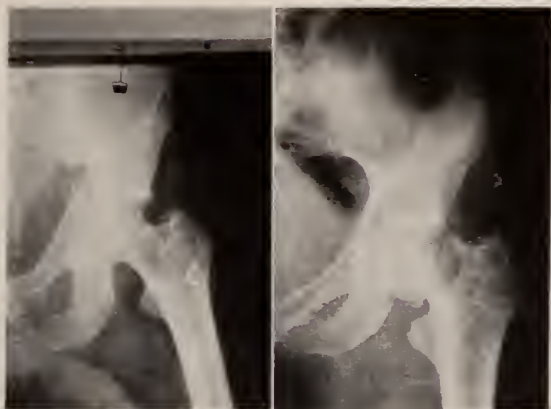


FIG. 1. Fracture of acetabulum.

FIG. 2. Fracture through femoral neck.

these nails requires careful judgment and is not the simple procedure that some writers imply.

Fractures through the trochanters are usually caused by indirect force. (*Figs. 6 and 7*). The femur at this point is large but cancellous. Four types of fractures may occur. The break may occur at the base of the neck but outside of the capsule. The break may go through the trochanters. In the third type, the base of the neck of the femur is deeply driven into the spongy bone of the trochanters and the lesser trochanter broken off. And lastly, the fracture traverses the trochanter and extends slightly down the shaft with the lesser trochanter displaced inward. The deformity caused by this fracture is characteristic: the leg is held in external rotation, slight abduction, and has some shortening. This shortening results from contraction of the powerful thigh and hamstring

motion, either active or passive, or any efforts to correct the rotation or shortening is met with a corresponding amount of pain. As long as the patient lies still in the position of deformity he is relatively comfortable. However, the deformity, if left alone, will result in a marked limp due in part to the actual shortening and in part to the conversion of an obtuse angle into an acute one. With rare exceptions this fracture should always be treated by continuous traction. The treatment by cast alone, without traction is mentioned only to be condemned as a shortened femur with a permanent limp is most likely to result.

The problem presented is to replace the fragments in correct alignment, correct the



FIG. 5. Moore's pins in fracture of neck of femur.



FIG. 3. Smith-Peterson nail. Anteroposterior view.

FIG. 4. Smith-Peterson nail. Lateral view.

muscles when stimulated by the pain caused by the misplaced fragments. Any attempt at

outward rotation, and to bring the angle formed by the shaft of the femur with the neck to its original approximate 127 degrees. There are many methods in use at present to accomplish this, such as the Thomas splint, skeletal traction, Hoke or Roger-Anderson well leg traction with their various modifications. Most of these methods, however, have adjustment devices for various degrees of traction and rotation. Since constant rotation, moving and twisting is carefully avoided in treatment of other fractures, I see no reason for making an exception of intertrochanteric fractures.

About five years ago I devised a right angle wooden appliance (*Fig. 8*) which could

be incorporated in the well leg traction cast and which has given uniformly satisfactory results in my series of 82 cases. This appliance is made from wooden strips, one by one and one-half inches. A right angle is



FIG. 6. Intertrochanteric fracture before reduction.

FIG. 7. Intertrochanteric fracture after reduction.

formed; one leg is made two feet long, the other one foot. A small brace is placed between the two legs for strength. The cost is about thirty cents.

The method is as follows: a cast is applied on the well leg from the toes to the groin. The knee is held in extension and the cast is well padded by the usual amount of sheet wadding reinforced by a felt strip extending along the internal aspect of the leg including the knee and ankle. A wooden frame is then incorporated in the cast over the area where the felt strip was applied (Fig. 9). The frame is directed toward the opposite foot and extends ten inches below the foot of the cast.

Under 2 per cent novocain local anesthesia, a Steinman pin is inserted through the crest of the tibia five inches above the ankle joint. The ends of the pin emerging through the skin are treated by collodion and gauze. The leg is now wrapped in sheet wadding and a cast applied from the knee to the toes. When the cast is sufficiently hardened, a three-inch muslin bandage is made to cross the end of the wooden appliance and extend up and over the Steinman pin on both sides. It will be found that the injured leg by this means can be slowly but firmly pulled down toward the foot of the wooden appliance. Within ten minutes the heel of the injured leg will be about one and one-half inches lower than the opposite heel. This I have found is sufficient traction. The foot is slightly internally rotated and a

plaster bandage made to incorporate the muslin bandage, pin and all. A small board now connects both casts at the area of the calf of both legs. This should always be posterior as the patient frequently complains of pain if placed anteriorly. An immediate x-ray check-up will usually show the fragments to lie in correct position. About twelve weeks should elapse before union is sufficient for removal of the cast.

During this time the patient can sit straight up in bed, and can even be placed in a wheel chair. At the end of twelve weeks when the cast is removed, the patient is permitted to be up on crutches for four weeks before the beginning of weight bearing. The fracture should be well in twenty weeks.



FIG. 8. Wooden appliance for well leg traction.

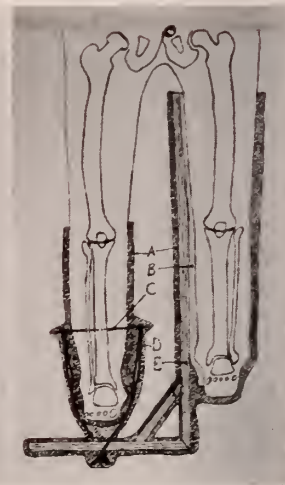


FIG. 9. Diagram of well leg traction.

A—Plaster cast  
B—Felt strip  
C—Steinman pin  
D—Muslin bandage for traction  
E—Wooden appliance

#### SUMMARY

1. Fractures of the acetabulum should be treated in traction.
2. Fractures of the femoral neck are best treated by internal mechanical fixation.
3. All hip fractures can be reduced during the first 48 hours under a local anesthetic.
4. All intertrochanteric fractures should be treated by continuous traction.
5. This traction should be adequate.
6. The traction should be maintained continuously for twelve weeks.
7. No weight bearing should be permitted for sixteen weeks.



## MANAGEMENT OF THE DIABETIC PATIENT

WITH CASE REPORTS

G. H. Garmany, M. D.  
Havana.

It is my hope that in this short paper on so large a subject I can mention a few things which while known to all of us, are sometimes forgotten, especially by the physician who is not particularly interested in diabetes or who sees only a few cases. Obviously, but a few of the many problems encountered can be mentioned.

With the discovery of insulin by Banting and Best the treatment of diabetes was revolutionized. Instead of considering the disease a hopeless condition, we may now confidently expect our diabetics to do as well or better than patients with other chronic incurable diseases. No longer is it necessary for the patient to undergo semi-starvation and eat the unpalatable high fat diets. Today, with the exception of sugar itself, diabetics may be given nearly normal diets and if well controlled may be inconvenienced very little by their disease. As in the pre-insulin days regulation of the diet still holds first place in the treatment, but only by a balance between diet, insulin and exercise can we hope for the best results.

Many dietary methods have been advocated. The trend of the past few years has been to feed more carbohydrate than was formerly thought advisable. As early as 1927 Sansum<sup>1</sup> reported the results on 400 cases over a three-year period taking a diet containing a carbohydrate-fat ratio of not less than two to one and often higher. These patients received in many instances 250 to 300 or more grams of carbohydrate a day. He found that in a large majority of cases in which these diets were used, while a temporary increase in insulin was necessary, patients looked better, felt better and were better satisfied and had little temptation to eat forbidden food. Many showed an increase in sugar tolerance and in spite of the enormous increase in carbohydrate allowance were able to reduce their insulin.

As would be expected, these patients receiving so little fat showed a marked drop in blood cholesterol. Theoretically, at least, this is a major consideration since cholesterol metabolism is so closely related to the frequent complication of diabetes, namely gall stones, arteriosclerosis and certain eye complications. Since Sansum's report, Rabinowitch,<sup>3</sup> Mosen-thal<sup>4</sup> and others have reported favorably on the high carbohydrate diets.

There are certain disadvantages to this diet, however. While it is high in carbohydrate it must necessarily be low in caloric value since so much fat has been taken out. Some patients tend to lose weight and others complain because they desire more fats. This diet is ideal for the patient who is obese.

The more conservative method used by Joslin<sup>5</sup> and others is probably the most commonly used, the most easily applied, and on the whole the most satisfactory in the hands of the average physician and patient. This is essentially a compromise between the extremely high and low carbohydrate diets. Usually about one and one-half, and rarely more than two, grams of carbohydrate are allowed for each gram of fat. This allows the patient to have a slice of bread with each meal, a pint of milk a day, as much five and ten per cent vegetables as desired and a reasonable amount of the more starchy vegetables. The remainder of the diet consists of fruits and, of course, protein and fat to form a balance.

This type of diet has the advantage over the one previously mentioned in that a higher caloric diet can more easily be fed and because it is more adaptable to the patient taking protamine insulin. I do not believe the high fat diet prescribed a few years ago has any excuse to exist today. Of course no strict rule can be made. The patient should be given that diet on which he is best satisfied as far as this is compatible with control of the disease. A patient dissatisfied with his diet will never be a cooperative patient.

Little need be said concerning the use of regular insulin. The introduction by Hagedorn of the slow acting protamine and later the more stable protamine zinc insulin has greatly added to our means of control, but has complicated rather than simplified our method. Since protamine zinc insulin is now

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Read before the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, Chattahoochee, April 21, 1938.



the insulin commercially available, it will hereafter be referred to simply as protamine insulin.

Protamine insulin is of advantage either alone or in conjunction with regular insulin in nearly every diabetic patient. Certainly it should be tried in every case in which one dose of regular insulin does not give adequate control. Protamine insulin is of particular value in early cases; cases having high fasting blood sugars in spite of the administration of regular insulin; in cases extremely sensitive to regular insulin; where there is resistance to regular insulin; in patients with low cardiac reserve or coronary disease who will not stand a sudden drop in blood sugar safely; during infection pre-coma or true coma supplemented with regular insulin; and in cases requiring surgery.

When regular insulin is given it begins to act immediately, reaches its maximum effect in about an hour, rapidly diminishes in effect and completely stops in four to six hours. Protamine insulin does not begin to act for several hours, gradually increases its effect and reaches a maximum in from twelve to twenty-four hours and may exert some effect up to or past seventy-two hours. This must be remembered when giving protamine insulin and the dose gradually reduced if necessary, since cumulative action might take place.

By gradual continuous action over a longer period of time protamine insulin maintains a more nearly normal blood sugar during those periods in which, if regular insulin were being given, there would be a tendency for blood sugar to increase. This not only brings about more nearly normal sugar metabolism, but since the rise in blood fats follows by several hours the rise in blood sugar it insures a more complete burning of fats during those hours in which regular insulin would have already lost its effect.

The best time to administer protamine insulin has not definitely been settled. In most cases it can be satisfactorily given before breakfast, but some patients are better controlled if the dose is given in the evening. Each case, of course, is an individual problem. New patients may be started on protamine insulin alone or regulated on regular insulin and then changed gradually to protamine. The last method is probably the easiest.

When a new patient is started on protamine insulin he should be given a dose somewhat under his estimated requirement and the amount increased at two or three-day intervals as it becomes necessary; unless the patient is in a state of acidosis there is no necessity to hurry. Give the insulin time to take effect. Providing no hypoglycemic symptoms occur the dose may be increased until the morning blood sugar is normal. It is never advisable to give more than this amount of protamine insulin. If this single dose is not sufficient to control the after meal rises in blood and urine sugar regular insulin must also be given. As sugar tolerance seems lowest after breakfast it is usually found that if regular insulin is also needed it is best administered before breakfast.

The diabetic already taking insulin may be transferred to protamine insulin by giving about two-thirds of the total day's requirement at a single dose before breakfast together with the remaining one-third regular insulin. These amounts are gradually shifted until the patient takes only protamine or until it is obvious that protamine alone will not be sufficient. Occasionally by giving a part of the carbohydrate in the forenoon, afternoon and at bedtime a case will be controlled by protamine alone which could not have been controlled had the patient been fed three equal meals. This slight change prevents any excessive carbohydrate intake at any one time.

A few words concerning the hypoglycemic reactions from protamine insulin are probably in order. Reactions do occur, but not as frequently as when the patient is taking regular insulin. These reactions may, however, be severe and prolonged. After recovery from a reaction the patient should take some slowly absorbed carbohydrate to prevent another reaction several hours later. Headache, nausea and vomiting are frequent symptoms of a protamine reaction. Sweats and tremors are not seen as frequently as in a regular insulin reaction.

Astonishingly low blood sugars are sometimes seen in patients taking protamine insulin, although no discomfort or symptoms of hypoglycemia are present. Apparently the severity of the reaction is proportional to the rapidity of drop in blood sugar. In general,

patients on protamine insulin experience a sense of well-being they did not have on the regular insulin alone, can almost always reduce the number of injections and on the whole are happier and more satisfied. Certain patients do not tolerate the new insulin and experience unpleasant local or general symptoms and had best be given regular insulin. Others, especially in cases of many years' standing, who have learned to control their disease by regulation of their lives, diet and insulin had best be left alone.

Joslin has repeatedly emphasized the beneficial effects of exercise in the well-controlled diabetic. A large part of the carbohydrate is oxidized in the muscles and by keeping the muscular system in good condition this process is improved not only during actual exercise, but also during periods of rest. Exercise, however, in the uncontrolled diabetic may be enough to precipitate a coma.

Although hospitalization for regulation of diabetes is ideal it is by no means imperative except in the infant, juvenile patient, or the occasional severe adult case. Thousands of cases have been perfectly treated in the office without a single blood sugar determination. The treatment of diabetes requires work and patience, but the job is rarely a thankless one.

Several case reports showing the success or failure of protamine insulin and the diets used will be given:

CASE NO. 1. This patient was a white male aged 32, somewhat obese, a minister by occupation and had sedentary habits. Sugar was first found in the urine eight years previously, but no further investigation was made or treatment advised at that time. Since that time he had had numerous urine examinations made, all of which contained sugar.

On coming under observation he complained of polyuria, polydipsia, excessive hunger, loss of weight, typical migraine headaches and infected feet. Here was an untreated case of at least eight years' duration. His case is unusual in that he had been able to take an unrestricted diet for so long without developing severe complications or even coma. His fasting blood sugar was 380 milligrams per hundred cc. of venous blood.

This patient was easily regulated on a diet of carbohydrate 180 grams, protein 80 grams and fat 110, 2030 calories and 15-10-10 units of insulin. He immediately felt better; his symptoms subsided and the infection cleared in his feet.

An attempt was made to change this patient to protamine insulin. At first 20 units of protamine and 10 units of regular insulin were given before breakfast. Finally one dose of protamine insulin, 30 units, was given before breakfast. Glycosuria was fairly well controlled, but the patient constantly complained of a feeling of apprehension and nervousness. This was not due to hypoglycemia since he was usually allowed to run a faint trace of sugar in his urine.

After several weeks' trial this patient insisted on returning to regular insulin. I do not attempt to explain this patient's symptoms. Whether they were psychic I do not know. Nevertheless, this case is similar to others reported in which patients suffered some discomfort while taking protamine insulin and had to return to regular insulin.

CASE NO. 2. This 23-year old white male is a patient in the Florida State Hospital. His mental diagnosis is dementia praecox and therefore poor in prognosis. Needless to say, psychotic patients who are diabetics are difficult to regulate due to their frequent refusal of food or to their stealing of food from other patients' trays. This patient was found to be a diabetic after several years in the Institution. Other than loss of weight and an abnormal appetite no other symptoms except glycosuria were found.

He was put on a diet of carbohydrate 150, protein 80 and fat 110, with insulin 20-15-20 before meals, a total of 55 units. This patient was well controlled, and since he was in the hospital and could be closely watched he was changed at once to protamine insulin alone. He was given 55 units protamine before breakfast, was well controlled from the beginning and we were soon able to reduce his dose to 25 units once a day. This illustrates a case where the patient was able to take much less insulin than formerly and to take one instead of three injections.

This patient was transferred from the hospital to the general wards where he remained sugar-free for some months. Recently, however, he was found to be out of control and will probably have to be readmitted to the hospital. This does not represent a failure of protamine insulin. This patient will steal anything edible at any time and has probably not been watched closely enough in this respect.

CASE NO. 3. This white male aged 23 had been a diabetic for nine years. Having developed diabetes at the age of 14, his was a severe case, as would be expected. Various diets and insulin doses were tried at one time or another. Several times he was admitted to the hospital for regulation. While his daytime glycosuria could be controlled he would have frequent hypoglycemic reactions before bedtime or shortly after, then his blood sugar would begin to rise and by morning his urine would show a four-plus sugar and a heavy trace of acetone. Thus, this patient from eight to twelve hours out of the twenty-four was virtually an untreated diabetic in a state of mild acidosis. Early in 1937 he was changed to a diet containing a much higher percentage of carbohydrate and a lower percentage of fat. He was given carbohydrate 140 grams, protein 90 grams and fat 110 grams. No more insulin was required than on the previous diet after a short period of adjustment. Contrast this diet with the one previously received, containing carbohydrate 75 grams, protein 110 grams and fat 140 grams. Seventy-five grams of carbohydrate represents that contained in three slices of bread and one glass of milk. Anyone doubting the disagreeable nature of this diet needs only to try it. He was still unstable at times after this change and would occasionally show heavy traces of sugar or have mild hypoglycemic reactions. He was better controlled, however, than on the previous diet. After about six months on this system of management he was transferred to protamine insulin with no change in diet. He was first given 30 units of protamine and 15 units of regular insulin before breakfast. The protamine was gradually increased and the regular insulin decreased until 55 units of protamine was given in one dose before breakfast. On this single dose his glycosuria was well controlled with the exception of about two hours after breakfast and two hours after the noon meal.

Much to our surprise on two occasions his morning fasting blood sugar was 27 milligrams and 42 milligrams respectively. On neither occasion did he have the slightest discomfort or any signs of hypoglycemia.



Criticism of the management of this case can justly be made. He was changed to protamine insulin too abruptly and was given a dose slightly in excess of his requirements although no harm resulted.

After about two weeks he was able to reduce his insulin and at present is taking 30 units of protamine insulin once a day. Recently, due to his having had several mild hypoglycemic reactions, his carbohydrate was increased to 160 grams, his protein kept at 90 grams and fat reduced to 100 grams. When last taken his morning fasting blood sugar was 112 milligrams. He is probably as well controlled as a diabetic can be considering that his is a juvenile case and therefore severe. Not only is he better controlled but he looks better and has gained about 14 pounds in the past year in spite of receiving a lower caloric diet than he previously received.

This case illustrates the striking general improvement in a patient when he is given a diet containing ample carbohydrates and a lesser amount of fat. This patient is almost perfectly controlled with one dose of protamine insulin 25 units less than when he was taking three doses of regular insulin.

CASE NO. 4. This was a white male aged 22. He was admitted to the Florida State Hospital principally for regulation of his diabetes. He had had some phobias and other neurotic symptoms, but was not psychotic. He had been a diabetic to his knowledge for about four years but had never been under strict management.

He entered a hospital in Thomasville, Georgia, in a precomatose condition. After sufficient recovery he was sent to the Florida State Hospital where I first saw him. Except for being markedly underweight nothing unusual was noted. His urine on admission showed a four-plus sugar and acetone. His blood sugar was not taken at this time.

He was put on a diet of carbohydrate 180 grams, protein 80 grams and fat 100 grams, but since we had trouble controlling his glycosuria his carbohydrate was reduced to 160 grams with no other change. He was started on protamine insulin 30 units and regular insulin 10 units before breakfast and 10 units before supper. His insulin had to be increased until he was taking 30 units of protamine and 15 units of regular insulin before breakfast, 15 units of regular insulin before the noon meal and 10 units before supper. Later he was put on 60 units of protamine and 15 units of regular insulin before breakfast, none being given at any other time.

He is now well controlled and shows only occasional traces of sugar in the urine. Recent morning fasting blood sugar showed 124 milligrams and 91 milligrams on two occasions. This patient has gained 19 pounds and is still slightly under his ideal weight, but will probably not be allowed to gain much more weight.

In spite of the general improvement in his condition he has had several attacks of furunculosis and has developed some troublesome skin lesions on his extremities which as yet have not been positively diagnosed.

Considering the severity of this case I do not believe he could have been controlled as well with any number of doses of regular insulin including one at midnight.

In conclusion I wish to reemphasize these few points:

1. Feed the diabetic a palatable diet and you will have a most appreciative and cooperative patient. Restrict the diet too much and few will cooperate.

2. The higher carbohydrate diets usually improve the patient's tolerance to sugar, lower the blood cholesterol, thus preventing certain complications, and usually make him feel better.

3. Protamine insulin should be tried in all cases either alone or in conjunction with regular insulin unless there is some very good reason not to try it.

4. By controlling the blood sugar throughout the 24 hours and preventing sudden fluctuation protamine insulin converts the patient into a more nearly normal individual and almost always makes him feel better.

5. Exercise will make the diabetic worse who is poorly controlled or taking little or no insulin, but in the well controlled case moderate exercise usually enables the patient to eat more, take less insulin, or both.

6. As in all other conditions individualize the treatment. No one system of management will suit all cases.

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## BRIEF REMARKS ON MALARIA

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The purpose of this paper is to present in a rather brief and clear fashion the necessary information for the diagnosis and treatment of malarial infections. Although the amount of literature upon this subject has been voluminous within the past decade, comparatively little has been written that is of value in either treating the disease or its control. A considerable amount of the current literature upon this subject is highly controversial, either claiming or disclaiming the value of certain specific drugs in its treatment, with few writers being willing to concede each drug its proper value. Such articles serve to cast a cloud upon the subject and to leave the practicing physician in a state of utter bewilderment so far as treating the disease and the final results are concerned. Despite the fact that we have specifics of proven value to combat the disease, some writers insist on giving the disease an almost hopeless prognosis so far as a final and complete cure may be obtained. In this paper I will endeavor to clarify the situation by presenting my own opinions and observations based upon some four hundred cases and carriers of malaria.

Before proceeding further in the diagnosis and treatment of malarial infections one must have a satisfactory classification for the disease. I have knowledge of no classification that is at all satisfactory from both a clinical and etiological basis. Osler<sup>1</sup> classified the disease from a clinical and etiological basis,

but this is sometimes confusing since one type would often simulate another. Since that time, to my knowledge, no satisfactory classification has been evolved. I suggest the following classification, based upon clinical and etiological findings, as being satisfactory both from the viewpoint of the therapist and the statistician, and one which should aid in obtaining more accurate data on the disease.

Malarial infections should be classified so as to show whether the individual is suffering from an acute infection, a chronic infection, or is a carrier of the disease. The acute infections will comprise the group of patients who do not have an enlarged spleen, a chronic secondary anemia or a history of recurrent infections. The chronic infections include those who have either the enlarged malarial spleen, the chronic anemia or a history of recurrent infections. The malarial carriers include those individuals who are harboring the parasites in the blood stream but exhibit no symptoms of the disease. Close examination will demonstrate that the true malarial carrier is quite rare as most of these cases on close examination will show some of the findings of a chronic malarial infection. These patients do not appear ill because of the development of a partial immunity that is able to prevent the parasites from developing in sufficient numbers to produce symptoms of the disease. There is no distinct boundary between the least severe cases of the chronic malaria and the malarial carrier, but this is of small importance as the treatment in both of these groups will be the same. In addition, the type of the malarial infection should always be given in the classification. The classification is represented schematically as follows and is self-explanatory:



It is quite obvious from the aforementioned classification that the only proper way to diagnose a malarial infection is by demonstrating the plasmodia in the blood of the affected individual. Statistics on malaria are without value unless corroborated by blood smear examination. I have seen many cases of chills and fever with repeated negative blood smears

for malarial parasites, in which the patients recovered without any specific anti-malarial medication, and with no recurrence of symptoms. In any group or community in which malarial fever is quite prevalent or which has become "malaria conscious," a relatively large number will interpret any chilly sensation as a chill of malarial fever. For this reason, I feel that any statistics on the incidence or treatment of this disease without the corroborating blood smear are of very little value and account for the wide variance of results obtained by different investigators. I do not advocate withholding specific treatment until confirmatory diagnosis is made by blood smear. If the symptoms justify the diagnosis, make a blood smear and then proceed with the treatment. If the laboratory confirms the diagnosis, only then, is it justifiable to consider the case as one of malaria. If no laboratory confirmation is forthcoming the proper diagnosis should be "observation for malarial fever" and the case not used in any malarial statistics.

Malarial infection, I believe, deserves a place of at least equal rank with syphilis as a simulator of other diseases. Osler<sup>1</sup> in his description of the disease mentioned many forms that it might take. I have seen malarial fever cases resembling everything from sunstroke, acute urticaria to an acute condition within the abdomen. With this in mind, a blood smear examination should be made almost routinely in areas that have a high incidence of malarial infections. This would save many lives.

Malarial infections are acquired through the bite of an *Anopheles* mosquito that is infected with the parasites. Infections, however, may occur in which the mosquito does not enter into the chain of events, although this is infrequent. This is often performed as a therapeutic measure in the treatment of neurosyphilis. Inadvertently, this might occur in blood transfusions if the donor unsuspectingly harbors the parasites, with disastrous results upon the recipient. In areas of endemic malaria, I feel that a blood smear examination should be routinely made on all prospective donors to prevent any such occurrence, particularly during an epidemic.

The treatment of malarial infections has

undergone many changes. It is like a pendulum swinging from extensive treatment to little or no treatment, but as the disease is better understood it is taking a position midway. It is a long way from the prolonged treatment given by Osler<sup>1</sup> to that of Hill and Olavarria<sup>2</sup>, and I believe the final solution will lie between the two. The ideal treatment will be one that is adequate to cure the disease, and yet not so prolonged or disagreeable as to encourage lack of cooperation by the patient.

The treatment of malarial infections may be divided into two parts, specific treatment and symptomatic treatment. Symptomatic treatment is given as dictated by the individual needs of the patient and it is impracticable to attempt to cover this phase in a paper of this size. In the specific treatment, I will restrict myself to the mention of three drugs that have amply proved their merits as therapeutic aids in this disease. These drugs are quinine, atabrine and plasmochin.

Quinine and atabrine may be used with equal facility in treating malarial infections. For the infections that would be classified as acute, a course of quinine consisting of thirty grains daily for eight days or atabrine four and a half grains daily for five days should suffice. For the chronic infections and the carriers, a longer course of therapy is indicated, quinine grains thirty daily for ten days or atabrine grains four and a half daily for eight days being sufficient. In estivo-autumnal infections plasmochin should be given in conjunction with atabrine or quinine in a dosage of .03 Gm. daily for five days. This should be adequate for the treatment of any case of malarial infection and can be used as a basis for determining the amount of treatment the individual case should have. Variation in the amount of medication should be made according to the age and size of the individual but the above is ample for the average person. In the more severe infections it is sometimes imperative that radical treatment be instituted. In these cases either atabrine or quinine might be given intravenously. Fifteen grains of quinine hydrochloride dissolved in three hundred cubic centimeters of sterile distilled water is allowed to flow slowly by the gravity method. This procedure as in-



dictated by the patient's condition may be repeated several times at four to six-hour intervals, but should be discontinued as soon as possible as there is a definite risk of fatal reaction. This writer is unfamiliar with the use of atabrine intravenously.

Quinine has received its position in the treatment of malarial infections by proving its merit over a long period of time and it should not be too hastily discarded in favor of more modern synthetic preparations. Given in adequate dosage, the number of cures will approximate that obtained with atabrine. The chief disadvantages as compared to atabrine are the longer period of treatment, the larger dosage, the temporary deafness and muscular weakness with resulting greater loss of time from work. Its chief advantage is its low cost.

Atabrine is a yellow, synthetic dye product of bitter taste. The only disadvantage that I have observed in its use is the yellow discoloration of the skin that often follows. Usually this discoloration will disappear within several months, but I have seen one individual in whom the color has persisted over a year. This factor should be borne in mind when treating fair skinned individuals. In addition, atabrine has been described as causing gastro-intestinal disturbances or mental symptoms. I have never seen a case in which such disturbances could be ascribed to the drug as in each case examination of the blood smear revealed sufficient number of parasites to account for all the symptoms.

I believe that atabrine has its greatest field in the group treatment and control of malarial infection, more so than in the individual case. Bispham<sup>3</sup> has shown the advantages of atabrine over quinine in treating malarial fever in the Civilian Conservation Corps with less loss of time from work. His recurrent rate compares favorably with those of other investigators and if the reinfections could have been separated from the recurrences, the results obtained would have been much better. Bispham<sup>3</sup> also demonstrated the value of three grains of atabrine weekly as a prophylactic in the prevention of malarial fever.

Plasmochin has only one place in the treatment of malarial infections and that is in the treatment of estivo-autumnal infections. The

sexual forms, the so-called crescents, are not materially affected by either quinine or atabrine, but respond rapidly to plasmochin. This drug has little or no value in the treatment of tertian and quartan infections, since both the sexual and asexual forms of these parasites respond readily to treatment with atabrine or quinine.

This paper is a summary of my experience on malarial infections in the southeastern part of the United States. Although a large amount of money has been spent on controlling the disease, the results obtained have not been in keeping with the cost. Extensive drainage projects and drug investigations have benefited local sections but have done little for the masses of people, particularly those in the more isolated areas and in poorer economic circumstances. For these people drainage is impracticable and extensive drug treatment would be costly and offer little in the way of permanent results. I believe the future pathway for controlling malaria in the more isolated sections of the country lies in education of the people concerning the disease. This can well be combined with hookworm eradication as both diseases are a public health problem and, I believe, can best be reached through education.

#### SUMMARY

1. Malarial infections are easily cured with adequate therapy.
2. The recurrence rate for malaria would be greatly reduced if the number of reinfections could be excluded.
3. Results obtained in malarial control should always be properly evaluated and should be based only upon proper laboratory confirmation.
4. Malarial infections should be properly classified if results are to be fairly evaluated.
5. The field that offers the greatest possibilities in malarial control lies in education.

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Sunday, January 29, at the Roosevelt Hotel,  
Jacksonville:

### SCHEDULE FOR PRE-CONVENTION MEETINGS

COMMITTEE	ROOM	TIME
Scientific Work .....	Parlor A	9:00 a. m.
Cancer Control .....	428	10:00 a. m.
Venereal Disease Control .....	230	10:30 a. m.
Tuberculosis and Public Health .....	228	10:30 a. m.
Executive .....	Parlor B	11:00 a. m.
Postgraduate Course .....	328	11:00 a. m.
Past Presidents .....	Parlor C	11:30 a. m.
Councilors .....	Annex B	12:00 noon
General Session .....	Ball Room	12:30 p. m.
Legislative .....	Parlor B	3:00 p. m.

## NATUROPATHS NOT AUTHORIZED TO DISPENSE NARCOTICS

For the information of the profession, published below is copy from an opinion rendered by Federal Judge Strum of the United States District Court for the Southern District of Florida on December 13, 1938, in two cases, one by W. T. Perry, plaintiff, and the other by Harold G. Detwiler, plaintiff, both against J. Edwin Larson, as United States Collector of Internal Revenue for the District of Florida.

### OPINION OF THE COURT

STRUM, District Judge:

In these two consolidated civil actions the plaintiffs are duly registered naturopathic physicians under Sec. 3469, et seq. C. G. L. Fla. 1927. In the first, Dr. Perry as plaintiff seeks to enjoin the defendant Collector of Internal Revenue from cancelling plaintiff's registration as a physician authorized to prescribe and dispense narcotic drugs and compelling plaintiff to surrender the special narcotic stamp and order forms heretofore issued to him by the Collector under the Harrison Narcotic Act. In the second, Dr. Detwiler as plaintiff seeks to compel the defendant Collector to register him under the Harrison Narcotic Act and to issue him a special narcotic stamp and order forms, which the Collector refuses to do. In both instances the Collector is acting pursuant to a recent opinion of the Attorney General of Florida that naturopathic physicians are not authorized to prescribe or dispense narcotic drugs under the Florida Narcotic Law.

Under Section 1 of the Harrison Narcotic Act, 26 U. S. C. A. 1383 (d) "physicians \* \* \* and other practitioners lawfully entitled to distribute, dispense, give away, or administer" narcotic drugs are entitled to register with the Collector and receive from him a special stamp and order forms to be used in the purchase of narcotics. Who are such physicians or other practitioners is to be determined by the law of the State where the applicant resides. *Bruer vs. Woodworth*, 22 Fed. (2) 577.

The Florida Narcotic Act, Chap. 16087, Acts of 1933, Sec. 1 (Sec. 3397 (2) Perm. Supp. to Comp. Gen. Laws) provides: "Physician; means a person authorized by law to practice medicine in this State and any other person authorized by law to treat sick and injured human beings in this state and to use, mix or otherwise prepare narcotic drugs in connection with such treatment." (Italics supplied).

## IMPORTANT COMMITTEE MEETINGS

As this Journal goes to press, there are ten meetings scheduled of standing committees of the State Association, to be held in Jacksonville, Sunday, January 29, at the Roosevelt Hotel.

Dr. Thomas O. Otto, chairman of the Association's Committee on Legislation and Public Policy, has called a meeting of his committee for 3 p. m. Doctor Otto has requested that the officers and interested members of the Association meet with his committee to assist in planning for necessary activities in connection with the coming legislature. It has been reported that some bills will be introduced which will not best serve the citizens of our State or protect their health. The medical men should, therefore, work together for the good of all concerned and not attempt to work as individuals or individual units.

In order that there may be unified action and careful consideration of the questions involved, those who are interested are urged to meet with the Committee on Legislation and Public Policy on Sunday, January 29.

All of the committee meetings at the pre-convention conference are important. The following is the schedule of meetings for



Sec. 3469, C. G. L. Fla. 1927 *et seq.* provides for the licensing of practitioners of naturopathy, which is there defined to mean "the use and practice of psychological, mechanical and material health sciences to aid in purifying, cleansing and normalizing human tissues for the preservation or restoration of health according to the fundamental principles of anatomy, physiology and applied psychology, as may be required." Naturopathic practice, as there recognized, employs amongst other elements phytotherapy, which means treatment by means or with the aid of plants or remedies of botanical origin. Plaintiffs assert that phytotherapy embraces all botanical preparations and their compounds, including morphine, a derivation of opium, which in turn is a product of botanical origin, from which they conclude they are authorized to prescribe and administer morphine and other narcotics of botanical origin.

The Florida Naturopath Act (Sec. 3469 *supra*), clearly does not regard naturopaths as medical doctors, nor the practice of naturopathy as a practice of medicine. Per contra, it authorizes licensees thereunder to practice the art of healing only in a limited and defined field called "naturopathy," which is defined by Dorland's American Medical Dictionary (16th Ed.) as "a drugless system of therapy (treatment) by the use of physical forces, such as air, light, water, heat, massage, etc." To this definition is to be added the use of phytotherapy, as recognized by the Florida statute.

Sec. 1 of the Naturopath Act (Sec. 3469 *supra*) immediately after recognizing phytotherapy as a permissible method of treatment in naturopathy, concludes with the following proviso: "provided, however, that nothing in this chapter shall be held or construed to authorize any naturopathic physician licensed hereunder to practice materia medica or surgery \* \* \*." As originally introduced, the word "major" preceded the word "surgery," but was stricken by amendment, so as to forbid all surgery to naturopaths.

Literally, materia means "medical material." To practice materia medica is to engage in that branch of medical science which deals with drugs, their sources, preparations and uses. The above quoted proviso is an express limitation upon or qualification of the general authority of naturopaths as expressed in the general enacting clauses which precede the proviso. McDonald v. United States, 279 U. S. 12; 73 L. Ed. 582; Cox v. Hart, 260 U. S. 427; 67 L. Ed. 332; Am. Exp. Co. v. United States, 212 U. S. 522; 53 L. Ed. 635.

Though phytotherapy relates generally to healing with the aid of remedies of botanical origin, whatever is included in the practice of materia medica, that is, that branch of medical science which deals with drugs, their sources, preparations, and uses,—is expressly forbidden to naturopaths by the proviso. Conover v. Maloney, 16 Fed. Supp. 419. Compare *In Re: Gerber*, 206 Pac. 1004, involving an osteopath, and Note 86 A. L. R. 626, 631. The statute authorizes naturopaths to deal with botanical remedies contemplated by phytotherapy, exclusive of those embraced in materia medica. Nor is the situation altered by the fact that narcotics are used merely as a palliative to overcome pain, rather than as a specific treatment for an ailment.

In Conover v. Maloney *supra*, denying a narcotic license to an osteopath under the New Jersey law, the limiting proviso was that an osteopathic license "shall not permit the holder thereof to prescribe or administer drugs for internal use in the treatment of any human disease, pain, injury," etc. Though differing in language the proviso of the Florida statute is of substantially the same purpose and scope. Bruer v. Woodworth, 22 Fed. (2) 577, and Hostetler v. Woodworth, 28 Fed. (2) 1003, construing a Michigan statute, here relied upon by plaintiffs, also dealt with osteopaths. Under the Michigan statute, however, the educational and professional requirements for licensed osteopaths are much broader and exacting, and the scope of their authorized

professional activities more extended, than those prescribed for Florida naturopaths. This is also true of the Washington statute construed in *Waldo v. Poe*, 14 Fed. (2) 749. Moreover, the limiting proviso of the Michigan statute that an osteopath's license shall not authorize the holder "to practice medicine," the latter being defined by another statute to include "the furnishing of any drug, medium, appliance, manipulation or method, or treatment by any therapeutic agent whatsoever," if literally construed would altogether prevent the osteopath from practicing, notwithstanding his license as an osteopathic "physician," thus creating an intolerable anomaly, which was pointed out in the first Michigan decision as one of the principal reasons for the decision. This is not true of the Florida statute. Applying the Florida statutory proviso as here construed, a broad field of practice is still open to Florida naturopaths, as defined in Sec. 3469 *et seq.* *supra*, even in the use of remedies embraced in phytotherapy. But drugs which are a part of materia medica are forbidden to the naturopath.

The view here expressed is fortified by the fact that although the Florida statute refers generally to phytotherapy as embraced within the practice of naturopathy, the course of study prescribed for naturopaths by the statute does not include a study of botanical compounds or extracts generally, nor of narcotics. This omission is in harmony with the restrictive proviso which prohibits the practice of materia medica by naturopaths. Neither in the Florida Naturopath Act nor the Narcotic Act is there specific authority for naturopaths to dispense or prescribe narcotics or other drugs. On the contrary, the proviso of the Naturopath Act expressly interdicts the practice of materia medica, which embraces narcotics.

If naturopaths are to prescribe or dispense narcotic drugs in the State of Florida, they must first secure legislative authority, as they are not now within the category of a physician, as specifically defined in Sec. 1 of the Florida Narcotic Act.

Judgment in each case for the defendant Collector.

## STUDY OF MEDICAL CARE QUESTIONNAIRES

On January 11 a letter was written to the secretary of each county medical society, enclosing a supply of forms 1F, to be filled out by physicians and dentists for the third period of seven days. The Bureau of Medical Economics of the American Medical Association is making preparations for a report which must be transmitted to its House of Delegates at its next session. February 28 has been set as the deadline for returns from county medical societies to be included in its report. This survey of the A. M. A. through the county medical societies of the nation will furnish very valuable data and the officers and members of the county medical societies in Florida are urged to lend their full cooperation.



## COST OF PNEUMONIA CARE

The average case of pneumonia in New York City costs \$167.60, according to "A Study of the Economics of Pneumonia" conducted by Joseph Hirsh, Research Associate of the Committee on Research in Medical Economics (*Public Health Reports*, December 9, 1938). This figure, according to Mr. Hirsh, may be taken as a fair average for the costs of pneumonia care in large cities, especially in the northeastern states.

If it is representative of the costs for diagnosis and treatment of pneumonia, the annual bill for this disease in the United States amounts to more than \$75,000,000.

"Pneumonia accounts for well in excess of 450,000 cases of illness a year in this country," Mr. Hirsh said, "approximately 25 per cent of which are fatal. This toll exceeds that of any other communicable disease. It also contributes to many thousands of deaths annually which are officially attributed to other causes, and the extent of this contribution has never been accurately evaluated."

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## A. M. A.'S STATEMENT TO THE PRESS

In an official statement released to the press Tuesday afternoon, Dec. 20, by Morris Fishbein, M. D., editor of *The Journal of the American Medical Association*, he quoted from the statement made by the Board of Trustees to the special session of the House of Delegates at its meeting at the Palmer House in Chicago on Sept. 16. The quote read:

"Shortly after the termination of the National Health Conference, an announcement was released to the newspapers and to the press of the United States indicating that the Department of Justice of the United States government proposed to seek an indictment of the American Medical Association as a monopoly, unless the American Medical Association, through its central organization or through its constituent society in the District of Columbia, consented to certain stipulations satisfactory to the Department of Justice in relationship to the nature of medical practice."

Following consideration by a reference committee, Dr. Fishbein said, the House of Delegates adopted the following statement:

"Your reference committee highly commends the Board of Trustees for its willingness to submit to investigation by any authorized agency on the nature of its organization, work, conduct and activity. Firm in the belief in the probity of our officers, and confident of their adherence to established federal law, your reference committee recommends that, in the event of an indictment, this House of Delegates gives full support to the Board of Trustees in defending such litigation to the utmost, with every means in its power, exhausting, if necessary, the last recourse of distinguished legal talent, to establish the ultimate right of organized medicine to use its disciplines to oppose types of contract practice damaging to the health of the public."

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## SPECIAL GRAND JURY RETURNS INDICTMENTS

The Special Federal Grand Jury, which has been conducting an investigation in Washington, D. C., for more than two months, returned indictments Dec. 20, it was reported in *The Journal of the American Medical Association* for Dec. 24.

These indictments charged violation of the Anti-Trust Laws against the American Medical Association, the Medical Society of the District of Columbia, the Harris County (Texas) Medical Society, the Washington (D. C.) Academy of Surgery, and twenty-one individuals. The specific test of applicability of the anti-trust statutes to the medical profession was based on the District of Columbia cooperative, known as Group Health Association, Inc. The indictment charged the defendants with conspiring to "hinder and obstruct Group Health Association, Inc., in obtaining access to hospital facilities for its members." The indictment was signed by Thurman Arnold, Assistant Attorney General of the United States, David A. Pine, United States Attorney for the District of Columbia, and John Henry Lewin, Allan Hart, Douglas B. Maggs, and Grant W. Kelleher, special assistants to the Attorney General. According to *United Press* reports, the indictment charged the defendants with "having combined and conspired together for the purpose of restraining trade in the District of Columbia," that is to say: (1) for the purpose of re-

straining Group Health Association, Inc., in its business of arranging for the provision of medical care and hospitalization to its members and their dependents on a risk-sharing prepayment basis, (2) for the purpose of restraining the members of Group Health Association, Inc., in Washington, in obtaining by cooperative efforts, adequate medical care for themselves and their dependents from doctors engaged in group medical practice on a risk-sharing prepayment basis, (3) for the purpose of restraining the doctors serving on the medical staff of said Group Health Association, Inc., in the pursuit of their calling, (4) for the purpose of restraining doctors (not on the medical staff of Group Health Association, Inc.) practicing in the District of Columbia, including the doctors so practicing who are made defendants herein, in the pursuit of their callings, (5) for the purpose of restraining the Washington hospitals in the business of operating such hospitals.

"In so doing, defendants have then and there engaged in an unlawful combination and conspiracy in restraint of trade in and of the District of Columbia, in violation of Section III of the Act of Congress on June 2, 1890, known as the Sherman Anti-Trust Act.

"Plans, understandings and agreements to accomplish the unlawful business herein above described were proposed, discussed and adopted at such meetings" (the indictment apparently refers here to meetings of the Medical Society of the District of Columbia, at which the Group Health Association, Inc., was discussed).

In announcing the decision of the government to press for criminal indictments, Mr. Arnold is reported to have said that such procedures seemed the only method to resolve the issues raised in the situation. The individuals indicted include Dr. Olin West, secretary and general manager of the American Medical Association, Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, Dr. Roscoe G. Leland, director of the Bureau of Medical Economics, Dr. William C. Woodward, director of the Bureau of Legal Medicine and Legislation, and Dr. William D. Cutter, secretary of the Council on Medical Education and Hospitals, all from the headquarters of the Association in Chicago. The following remaining individuals named in the

indictment are all from the District of Columbia: Drs. Arthur C. Christie, Coursen B. Conklin, James Bayard Gregg Custis, Thomas A. Groover, Robert A. Hooe, Leon A. Martel, Thomas E. Mattingly, Francis X. McGovern, Thomas E. Neill, Edward H. Reede, William M. Sprigg, William J. Stanton, John O. Warfield Jr., Prentiss Willson, Wallace M. Yater and Joseph R. Young.

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### MEDICAL MOTION PICTURES AVAILABLE FOR LOAN

Motion pictures on various scientific subjects are available on a loan basis from the American Medical Association. The material falls into two groups

1. Pictures for medical societies and other scientific organizations;
2. Pictures for the public.

Requests for films should be instituted as far in advance as possible, so that the proper reservations can be made. The exact shipping addresses and dates should be given at the time of the request; also the type of apparatus in which the film is to be run. Responsibility for the projection and care of the film must be borne by the individual or organization which is borrowing it. The American Medical Association does not have projectors available for loan.

The only expense incurred is that of transportation both ways. However, careless handling resulting in serious damage may be charged to the borrower.

A brief description of each film may be secured from the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn St., Chicago, Ill.

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### DADE COUNTY BROADCASTS

It has been said that: "If there is one thing that interests everybody, it is a baby." If this be true, then many listeners will welcome the inauguration of the new programs entitled, "Your friend the Doctor," with the first of a series of weekly fifteen-minute dramatizations each Friday night at 9:00 p. m. over WQAM.

These dramatizations of educational facts are prepared and released by the American Medical Association through the Florida State Medical Association to be broadcast in the



interest of greater understanding of commonplace health problems and to encourage more helpful relations between the patient and the doctor.

The first program this Friday treats with the amusing incidents concerning the advent of the first baby to the Durand family, having for its locale the hospital room of the new mother, where the long-suffering father has just been admitted for the first time, following the big event.

The broadcasting of these vital programs in the Miami area is being done under the sponsorship of three local institutions: the Surgical Selling Company, 136 N. E. First Street; Fossett's Prescription Pharmacy, 168 S. E. First Street; and the Hart Drug Corporation, Pharmaceutical Manufacturers to the medical profession, in cooperation with the Public Relations department of the Florida State Medical Association.

—Bull. Dade Co. Med. Assn., January, 1939.

## OPHTHALMOLOGIC EXAMINATIONS

The American Board of Ophthalmology announces an important change in its method of examination of candidates for the Board's certificate.

Examinations will be divided into two parts. Candidates whose applications are accepted will be required to pass a written examination which will be held simultaneously in various cities throughout the country approximately 60 days prior to the date of the oral examination. The written examination will include all of the subjects previously covered by the practical and oral examinations.

Oral examinations will be held at the time and place of the meeting of the American Medical Association and of the American Academy of Ophthalmology and Oto-Laryngology, and occasionally in connection with other important medical meetings. The oral examination will be on the following subjects: External Diseases, Ophthalmoscopy, Pathology, Refraction, Ocular Motility, Practical Surgery.

Only those candidates who pass the written examination and who have presented satisfactory case reports will be permitted to appear for the oral examination.

Examinations scheduled for 1939: *Written*: March 15 and August 5. *Oral*: St. Louis, May 15; Chicago, October 6.

Applicants for permission to take the written examination March 15 must be filed with the Secretary not later than February 15.

Application forms and detailed information should be secured at once from Dr. John Green, Secretary, 6830 Waterman Ave., St. Louis, Mo.

## MEDICAL LICENSES GRANTED

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that 56 of the 74 physicians who took the written examination held in Jacksonville, November 14 and 15, have been licensed to practice medicine in Florida. It is interesting to note that of the 18 who failed, 12 graduated from medical schools prior to 1925. Thirty-five medical schools were represented, lead by Emory and Northwestern, each of which had five successful candidates.

Dr. Paul Eskeberg of Miami (Northwestern, 1938) and Dr. Frank Tressler Linz of Tampa (U. of Ohio, 1938) tied for the highest average of 87.5, and Dr. Frank Norman Pansch of Rochester, Minn. (Northwestern, 1937) ran a close second with 87.1.

## SUCCESSFUL APPLICANTS

John William Allgood, Jr.; Grady Hospital, Atlanta, Georgia (Emory, 1938).  
Leonard Sidney Annis; Tampa Municipal Hospital, Tampa (Emory, 1938).  
Rufus Andrew Askew; 910 Candler Building, Atlanta, Georgia (Georgia, 1938).  
Samuel Lawrence Balofsky; 702 13th Street, Miami Beach (Tulane, 1932).  
Jacob Arnold Barga; 801 Fourth Street, S. W., Rochester, Minnesota (Rush, 1921).  
Orville Leon Barks; Tampa Municipal Hospital, Tampa (Washington of St. Louis, 1938).  
William Frederick Bay; 212 23rd Street, Bradenton (Ohio Med. Univ., 1894).  
John Lester Berry; Richmond, Vermont (Vermont, 1929).  
Jack Holtzclaw Bowen; 700 West Tenth Street, Jacksonville (Emory, 1938).  
William Arnold Christian; 3612 West Franklin Boulevard, Chicago, Illinois (Illinois, 1933).  
J. Kenneth Cole; Box 81, Phelps, New York (Michigan, 1923).  
Thomas Edward Daly; Good Samaritan Hospital, West Palm Beach (Pennsylvania, 1936).  
Paul Eskeberg; 2731 N. W. 16th Street, Miami (Northwestern, 1938).  
Ira Chenault Evans; Tampa Municipal Hospital, Tampa (Virginia, 1938).  
Milo Fritz; Duke Hospital, Durham, North Carolina (Columbia, 1934).  
Samuel James Goldberg; 43 Trumbull Street, New Haven, Connecticut (Yale, 1907).  
Thomas Skaggs Gowin; 1021½ N. W. 4th Avenue, Miami (Louisville, 1938).



James Clarence Griffin; Tampa Municipal Hospital, Tampa (Tennessee, 1938).  
 Robert Fulmer Guthrie; 4112 Court S, Birmingham, Alabama (Emory, 1934).  
 Aldentus Franklin Harrison; Lamar, South Carolina (South Carolina, 1936).  
 William Rufus Hartness, Jr.; Tampa Municipal Hospital, Tampa (Louisville, 1938).  
 Carl Frederick Haub; 1810 N. W. 17th Avenue, Miami (Temple, 1937).  
 David Peterson Hightower; Hillman Hospital, Birmingham, Alabama (Tulane, 1937).  
 Ralph Abram Hurd; 37 East 64th Street, New York City (Columbia, 1915).  
 Raymond Lovejoy Johnson; Waycross, Georgia (Maryland, 1914).  
 Saul Harvey Kaplan; 916 Washington Avenue, Miami Beach (Rush, 1932).  
 Robert P. Keiser; Jackson Memorial Hospital, Miami (Ohio, 1937).  
 John Albert Kelk; 715-B Woodlawn Boulevard, Orlando (Albany, 1920).  
 Walter Appleton Lane; 173 School Street, Milton, Massachusetts (Harvard, 1899).  
 Harry C. Lawther; 410 S. W. 10th Avenue, Miami (Michigan, 1938).  
 Frederick LeDrew; Route 1, Box 2128, Miami (Toronto, 1926).  
 Jack Manual Levin; 915 Candler Building, Atlanta, Georgia (Emory, 1935).  
 Frank Tressler Linz; Tampa Municipal Hospital, Tampa (Ohio, 1938).  
 Patrick Joseph Lynam; 68 Narragansett Avenue, Jamestown, Rhode Island (Tufts, 1929).  
 George Maksim, Jr.; 916 Monroe Avenue, Elizabeth, New Jersey (Temple, 1933).  
 Francis Jacob Mantell; Veterans Administration, Bay Pines, Florida (Northwestern, 1928).  
 Lillian E. Cohen Mark; 1600 West Maypole, Chicago, Illinois (Tennessee, 1937).  
 John Joseph McAndrew; Victoria Hospital, Miami (Georgetown, 1937).  
 Paul Oram Messner; 317 South Main Street, Cambridge Springs, Pennsylvania (Medical Evangelists, 1934).  
 Royston Miller; Jackson Memorial Hospital, Miami (Maryland, 1938).  
 Marcus Eugene Morrison; St. Vincent's Hospital, Jacksonville (Tennessee, 1938).  
 Daniel Forney Hoke Murphy; 2408 Sunset Drive, Tampa (Vanderbilt, 1935).  
 Edmund Myers; 291 Shawmut Avenue, Boston, Massachusetts (Jefferson, 1908).  
 Robert Mitchell Oliver; Dillon, South Carolina (Pennsylvania, 1933).  
 Frank Norman Pansch; Mayo Clinic, Rochester, Minnesota (Northwestern, 1937).  
 Tilden Hendricks Phipps, Jr.; Tampa Municipal Hospital, Tampa (Oklahoma, 1938).  
 Simpson Daniel Puttler; Veterans Administration, Bay Pines, Florida (Medical Evangelists, 1934).  
 Avery P. Rowlette; 1515 Lafayette Avenue, St. Louis, Missouri (Washington of St. Louis, 1929).  
 Sol Selevan; 1670 S. W. 15th Street, Miami (Michigan, 1938).  
 Thomas LaVere Sisney; Box 1192, Pittsburgh, Pennsylvania (Pennsylvania, 1912).  
 Lester Stepmeyer; 6123 Madison Road, Cincinnati, Ohio (Eclectic Medical of Cincinnati, 1935).  
 John Augustus Toomey; 1051 Nicholson Avenue, Lakewood, Ohio (Western Reserve, 1919).  
 Aquilla Scott Turk; Jackson Memorial Hospital, Miami (Emory, 1938).  
 Richard Henry Walker, Jr.; Box 194, Johnson City, Tennessee (Virginia, 1927).  
 Walter Whayne Webb; 770 Fidelity Medical Building, Dayton, Ohio (Northwestern, 1933).  
 Orville M. Wright; 415 Troy Street, Dayton, Ohio (Northwestern, 1932).

## STATE NEWS ITEMS

Dr. L. C. Gonzalez of Jacksonville was recently appointed Director of the Division of Venereal Disease Control of the State Board of Health. Dr. W. A. McPhaul, State Health Officer, in making the announcement, stated that under the program planned, the new division will work in cooperation with the Venereal Disease Control Committee of the Florida Medical Association, of which Dr. E. T. Sellers of Jacksonville is chairman.

\* \* \*

The Fall meeting of the Florida Radiological Society was held at the San Juan Hotel in Orlando on November 12 and 13, under the chairmanship of Dr. Harold O. Brown, president of the Society. The scientific program consisted of presentation of interesting films followed by free discussion by the various members. The Sunday afternoon session was devoted to discussion of therapeutic problems in radiology under the chairmanship of Dr. J. N. Moore.

The following members were present: J. Maxey Dell, Jr., J. C. Dickinson, O. O. Feaster, E. M. Hendricks, F. K. Herpel, T. H. Lipscomb, Jos. H. Lucinian, J. J. McGuire, J. N. Moore, F. J. Payton, Nelson Pearson, J. A. Pines, G. Raap, W. M. Shaw, W. A. Weed, and Doctors Gray and Jares as guests.

\* \* \*

The Florida Medical Association was well represented at the International Medical Assembly held in Philadelphia, October 31 to November 4. The following doctors were present:

*Bradenton:* M. M. Harrison. *Clearwater:* J. S. Hood. *Daytona Beach:* James E. Rawlings.

*Jacksonville:* Stanley Erwin, Charles F. Henley, Louie Limbaugh, Kenneth A. Morris. *Jacksonville Beach:* Earl H. Roberts.

*Miami:* Samuel Aronovitz, Laura M. Hobbs, Young C. Lott, John W. Snyder. *Miami Beach:* W. Duncan Owens.

*Orlando:* L. N. Christensen. *Palatka:* Allen P. Gurganious. *Tampa:* Stephen Gyland. *St. Augustine:* A. C. Walkup.

\* \* \*

Please turn to page 364 and note announcement of the 1939 Florida Medical Directory. Last year the supply of Directories was exhausted long before the end of the year. A sufficient number of 1939 Medical Directories have been ordered to take care of your needs.

One free copy will be mailed to each member of the State Medical Association who paid 1938 dues.

If you lose or misplace your Directory, or need an extra one, forward \$1.00 to Box 1018, Jacksonville, and a copy will be mailed to you immediately.

The cooperation of Dr. W. M. Rowlett, secretary of the State Board of Medical Examiners; Dr. W. A. McPhaul, State Health Officer; and the various officers of the A. M. A. is acknowledged.

\* \* \*

The new Lee Memorial Hospital, Ft. Myers, assured by a \$100,000 WPA project, will be located in Edison Park, by recent action of the hospital directors.

\* \* \*

Wauchula is to have a new, modern hospital. Dr. Allen A. Poucher stated that the Wauchula Infirmary is to be moved from its present site and converted into a first class hospital.

\* \* \*

An educational program to combat venereal disease was launched in St. Petersburg recently. Dr. Alvin L. Mills gave the first lecture, for nurses, December 7 at St. Anthony's Hospital. Doctor Mills is a member of the Florida Medical Association's Committee on Venereal Disease Control. The following day, Dr. C. S. Franckle addressed the senior high school boys in the afternoon and Dr. A. R. Frederick addressed the senior high school girls.

\* \* \*

Dr. W. W. Hardman, formerly connected with the Veterans' Administration, Wadsworth, Kansas, is now located in Orlando. Doctor Hardman's offices will be in the Florida Bank Building.

\* \* \*

There is now a complete bound set of the Quarterly Cumulative Index to Current Medical Literature in the office of the Florida Medical Association. It begins with Volume 1, January, 1916, and is complete to date. The securing of missing volumes had been an arduous task. The last volume to complete the Association's set has been sought for several years. It was Volume 9, 1924. Recently Dr. J. C. Dickinson of Tampa loaned this volume to the Association on a t. f. basis. The officers and members of the Asso-

ciation are indebted to Doctor Dickinson for his generosity. The Index Medicus is used daily in the Association's office and the completed set will now be available for continuous use.

\* \* \*

Dr. Joseph Ruskin of Tampa won first flight honors in the November tournament at the Davis Island Golf Course.

\* \* \*

Dr. Charles L. Park of Sanford was recently appointed part-time county physician for Volusia County, and Dr. C. E. Tribble of DeLand was appointed county surgeon.

\* \* \*

Dr. Miles A. Collier has opened offices in the Stenstrom Building, over the Royal Theatre in Wauchula. Doctor Collier was formerly located in Bartow.

\* \* \*

A clipping from a Cuban newspaper indicates that Dr. Henry Hanson, a member of the Duval County Medical Society, Jacksonville, is well on his way to Ecuador. After a short stay there, he will go to Bolivia and Peru. Doctor Hanson recently visited in Jacksonville and is now on his way back to his regular work as traveling representative of the Pan-American Sanitary Bureau.

\* \* \*

Dr. James J. Nugent of Miami spent the months of September and October in New York City, attending urologic clinics. Doctor Nugent was present at the convention of the American College of Surgeons while in the North.

\* \* \*

Dr. J. L. Kirby-Smith of Jacksonville held a dermatological clinic at Eastman, Ga., December 6, at the Coleman Hospital, as guest of the district medical men at their quarterly meeting.

\* \* \*

Dr. Joseph Rose of Jacksonville was recently awarded the Army Fourth Corps Area appointment to the School of Aviation Medicine.

\* \* \*

Tentative programs are now available for the first American Congress on Obstetrics and Gynecology, which is to be held in Cleveland on September 11-15, 1939. For further information, address the headquarters office, 650 Rush Street, Chicago.

The dramas in the series of weekly radio programs by the American Medical Association and the National Broadcasting Company for February will deal with the general subject "Health for Tomorrow." The weekly topics will be "Avoiding Arthritis"; "Healthy Hearts"; "Cancer Can Be Cured"; and "Diabetes." This program is broadcast over the Blue network of N. B. C. each Wednesday at 2 p. m., e. s. t.

\* \* \*

### BIRTHS

Dr. and Mrs. O. E. Harrell of Jacksonville announce the birth of a son, James Edward, on December 26.

Dr. and Mrs. S. Charles Werblow of Miami announce the birth of a daughter, Lynne, on November 20, 1938.

Dr. and Mrs. Frank Woods of Miami announce the birth of a son, Frank, Jr., on November 29, 1938.

\* \* \*

### ERRATUM

The president of the Florida Public Health Association is Mr. S. D. Macready. Last month's Journal erroneously listed Dr. A. B. McCreary as president.

\* \* \*

### COMPONENT COUNTY SOCIETIES

#### ALACHUA COUNTY MEDICAL SOCIETY

The Alachua County Medical Society met December 9 at the Primrose Grill. A constitution and by-laws were adopted. A special committee had been appointed to draft the constitution and by-laws and this committee's report was officially accepted.

The question of forming a prenatal clinic was discussed. On motion, the president was instructed to appoint a committee of three to meet with the welfare board and report back to the society at its next meeting. The president appointed the following committee: Drs. H. M. Merchant, J. M. Dell, Jr., and J. H. Thomas.

A very interesting paper was presented by Dr. E. H. Andrews on "Intravenous Sucrose." A motion was passed to have a committee appointed to edit papers presented in local newspapers and before civic clubs on the subject of socialized medicine.

Official action was taken by the society, endorsing Dr. Wilburn Lassiter as full-time health officer. Doctor Lassiter is an experienced health officer, having served for many years in that capacity. He has been local reg-

istrar of vital statistics under the State Board of Health since 1917.

The following officers were elected: president, Dr. J. E. Maines, Jr.; president-elect, Dr. E. H. Andrews; vice-president, Dr. J. M. Anderson; secretary-treasurer, Dr. J. M. Dell, Jr.; delegate to State Association, Dr. J. L. Summerlin; and alternate, Dr. E. H. Andrews. The meeting was well attended and those present entered into the spirit of the occasion.

\* \* \*

#### BAY COUNTY MEDICAL SOCIETY

At the annual meeting of the Bay County Medical Society, the following officers were elected to serve for 1939: president, Dr. Donald S. Fraser; vice-president, Dr. Amsie H. Lisenby; secretary-treasurer, Dr. William C. Roberts. These officers are all from Panama City.

\* \* \*

#### BROWARD COUNTY MEDICAL SOCIETY

The following officers have been elected by the Broward County Medical Society: president, Dr. R. L. Elliston; vice-president, Dr. F. D. Pierce; secretary-treasurer, Dr. O. C. Brown. These officers are all from Ft. Lauderdale.

\* \* \*

#### COLUMBIA COUNTY MEDICAL SOCIETY

At the annual meeting of the Columbia County Medical Society, held December 16 at the Blanche Hotel, Lake City, the following officers were elected: president, Dr. W. M. Ives; vice-president, Dr. E. F. Brown; secretary-treasurer, Dr. H. S. Howell.

\* \* \*

#### DADE COUNTY MEDICAL SOCIETY

At the recent annual meeting of the Dade County Medical Society, the following officers were elected: president, Dr. M. J. Flipse; vice-president, Dr. Kenneth Phillips; secretary, Dr. Franz Stewart; and treasurer, Dr. Scheffel H. Wright.

\* \* \*

#### DE SOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES COUNTY MEDICAL SOCIETY

At the meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society held December 13, Dr. Ben D. Spears of Wauchula was elected president; Dr. John A. Simmons of Arcadia, vice-president; and Dr. H. V. Weems of Sebring was re-elected secretary and treasurer.



DUVAL COUNTY MEDICAL SOCIETY

Officers of the Duval County Medical Society, recently elected, are: Dr. Thomas E. Buckman, president; Dr. Charles B. Mabry, president-elect; Dr. George W. Croft, vice-president; Dr. Lauren M. Sompayrac, secretary; Dr. Alan D. Brown, treasurer; and Dr. Edward Jelks, parliamentarian. Elected to the Board of Governors: Drs. W. McL. Shaw, chairman, Kenneth A. Morris, and J. Lunsford Boone.

\* \* \*

ESCAMBIA COUNTY MEDICAL SOCIETY

The Escambia County Medical Society held its annual election of officers on December 13. The officers chosen for 1939 were: president, Dr. L. C. Fisher; vice-president, Dr. W. P. Hixon; secretary-treasurer, Dr. J. M. Hoffman.

\* \* \*

FRANKLIN-GULF COUNTY MEDICAL SOCIETY

A meeting of the Franklin-Gulf County Medical Society was held at Port St. Joe, Thursday, December 15. Every member of this new society was present. Among the first official actions taken by this society was to set an official date for regular monthly meetings. The third Thursday of each month was agreed upon. The meeting places will rotate. Local dues for this medical society will be \$1.00 semi-annually, making a total of \$2.00 for the year. This newest county medical society joins the one hundred per cent societies of the state in that all of its members have paid state dues for 1938.

The officers of the State Medical Association are very much pleased to note the enthusiasm with which this new society has been launched. The doctors in these counties will be in a better position to improve themselves in scientific medicine and thereby render a better service to the citizens of their community. Congratulations and best wishes to the members of the Franklin-Gulf County Medical Society.

\* \* \*

HILLSBOROUGH COUNTY MEDICAL SOCIETY

At the annual meeting of the Hillsborough County Medical Society held recently, the following officers were elected for the ensuing year: president, Dr. J. W. Alsobrook, Plant City; vice-president, Dr. T. C. Maguire, Plant City; and secretary-treasurer, Dr. J. S. Grable, Tampa. Dr. L. B. Mitchell was named censor and Drs. W. M. Rowlett, R. S. Torbett, and

H. Mason Smith were elected delegates to the next annual meeting of the State Association.

\* \* \*

LAKE COUNTY MEDICAL SOCIETY

The annual election of officers of the Lake County Medical Society, held in December, resulted as follows: president, Dr. W. G. DeVane, Groveland; vice-president, Dr. W. L. Ashton, Umatilla; secretary-treasurer, Dr. Terry Bird, Tavares; delegates to convention, Doctors DeVane and Aslton.

\* \* \*

LEE COUNTY MEDICAL SOCIETY

At the annual meeting of the Lee County Medical Society, the following officers were elected: president, Dr. Gordon C. Merrick, Ft. Myers; vice-president, Dr. Fred Bartleson, Ft. Myers; secretary-treasurer, Dr. H. L. Allen, Ft. Myers.

\* \* \*

MARION COUNTY MEDICAL SOCIETY

Officers for 1939 have been elected by the Marion County Medical Society, as follows: president, Dr. Carl S. Lytle, Dunnellon; vice-president, Dr. James L. Strange, McIntosh; secretary-treasurer, Dr. R. C. Cumming, Ocala.

\* \* \*

ORANGE COUNTY MEDICAL SOCIETY

At the meeting of the Orange County Medical Society held in December, Dr. George Russell Crisler of Winter Park was elected to membership.

The officers elected to serve for the coming year were; president, Dr. C. D. Hoffmann; president-elect, Dr. C. J. Collins; vice-president, Dr. Claude Anderson; secretary and reporter, Dr. Fred Mathers; and treasurer, Dr. Russell B. Carson. Delegates to the next annual meeting of the State Association: Drs. J. R. Chappell, Hewitt Johnston, H. A. Day, and Louis Orr; alternates: Drs. R. D. Thompson, C. J. Collins, D. T. McEwan, and T. E. McBride.

\* \* \*

PALM BEACH COUNTY MEDICAL SOCIETY

The annual meeting of the Palm Beach County Medical Society was held at the Brazilian Court Hotel, Palm Beach, on the evening of December 19. The following officers were elected: Dr. Gaylord Lewis, president; Dr. G. W. Heath, vice-president; Dr. C. J. Derrick, secretary; and Dr. Frederick K. Herpel, treasurer.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL  
SOCIETY

Dr. David B. Manley of Zephyrhills entertained the Pasco-Hernando-Citrus County Medical Society at a full course turkey dinner at the Edwinola Hotel, Thursday evening, December 8. The following were elected officers for the year 1939: Dr. Claude L. Carter, Inverness, president; Dr. H. L. Harrell, Dade City, vice-president for Pasco County; Dr. A. C. Coogler, Brooksville, vice-president for Hernando County; and Dr. G. R. Creekmore of Brooksville was re-elected secretary and treasurer. Elected to the Board of Censors were: Dr. S. C. Harvard, Hernando County; Dr. George A. Dame, Citrus County; and Dr. W. W. Jones, Pasco County.

Dr. Claude L. Carter was elected delegate to the State Medical Association meeting, with Dr. S. C. Harvard, alternate delegate.

Dr. James L. Estes of Tampa, guest speaker, gave a very interesting talk on "Pyelitis in Women" which was discussed by the other physicians present. Dr. W. H. Walters invited the Society to hold its next regular meeting with him in Lacoochee, January 12, 1939.

Members present were: Drs. Bradshaw, Carter, Creekmore, George Dame, Harrell, Harvard, Walters, Jones, Manley, Sistrunk; visitors: Drs. James L. Estes and Griffin of Tampa.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held a meeting at the Clearwater Yacht Club on the evening of December 2, at 6 o'clock.

On December 13 the Auxiliary to the Society entertained the members of the Pinellas County Medical Society at a dinner and dance held at the Yacht Club in St. Petersburg. Vocal as well as waltz abilities were tested as everyone participated in the singing of Christmas carols, with Dr. Prescott LeBreton, as accompanist.

The Society announces that on January 28, Dr. Russell LaFayette Cecil of New York City will be guest speaker at a meeting which will probably be held at the Princess Martha Hotel. Members of the Florida Medical Association who find it convenient to attend, are cordially invited to be present.

## POLK COUNTY MEDICAL SOCIETY

The December meeting of the Polk County Medical Society was held at the Civic Center, Bartow, December 14. Following the serving of the delicious turkey dinner, the business of the Society was taken up with the retiring president, Dr. W. W. Shafer of Haines City, presiding.

The election of officers was held which resulted as follows: president, Dr. J. F. Wilson; vice-president, Dr. Paul Bird; secretary-treasurer, Dr. J. R. Boulware. All of the officers are from Lakeland. Dr. R. E. Wilhoyte of Lake Wales was elected to the Board of Censors.

The program for the evening consisted of two informative papers: "The Eclamptic Patient" by Dr. T. C. Keramidias of Winter Haven, and "X-ray Diagnosis of Skull Conditions" (illustrated by slides) by Dr. J. J. Jares of Lakeland.

\* \* \*

## PUTNAM COUNTY MEDICAL SOCIETY

Dr. G. M. Zeagler of Palatka was host to the Putnam County Medical Society on the evening of December 13 at his grove on the St. Johns River near Welaka. A delicious quail dinner was served.

Quite a number of guest doctors from surrounding towns were present. The guest speaker of the evening was Dr. Robert B. McIver of Jacksonville, whose subject was "Kidney Disease and its Management in Pregnancy." Dr. J. E. Lopez-Silvero of Havana, Cuba, secretary of the Pan-American Medical Association, was also a distinguished guest.

The usual matters of business were transacted. President Z. Brantley, the presiding officer, expressed his appreciation of the interest the local doctors have taken in the activities of the society. The next annual meeting of the Northeast Medical District will be held in Palatka and the members of this society are looking forward with interest to that occasion.

\* \* \*

## ST. JOHNS COUNTY MEDICAL SOCIETY

A meeting of the St. Johns County Medical Society was held Tuesday evening, December 20, with Dr. H. E. White of St. Augustine as host at his home. An election of officers was held, which resulted as follows: president, Dr. R. D. Harris; vice-president, Dr. C. C. Grace; secretary, Dr. G. Walter Potter; treasurer,

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Dr. A. C. Walkup. Dr. G. Walter Potter and Dr. H. E. White were elected delegates to the State Medical Association convention at Daytona Beach in the spring.

\* \* \*

#### SARASOTA COUNTY MEDICAL SOCIETY

At the recent annual meeting of the Sarasota County Medical Society, Dr. T. W. Taylor of Sarasota was elected president for the ensuing year, and Dr. Stanley T. Martin of Sarasota was chosen to serve as secretary-treasurer. Drs. J. E. Harris and Millard White were elected Delegates.

\* \* \*

#### SEMINOLE COUNTY MEDICAL SOCIETY

The Seminole County Medical Society recently held its annual meeting at Sanford. Dr. T. F. McDaniel was elected president for the new year and the other officers named were: Dr. W. H. Garner, vice-president; Dr. D. G. Scott, secretary and treasurer. Dr. C. M. Mitchell was voted censor for three years and Dr. T. F. McDaniel was selected delegate to the next convention of the State Association.

\* \* \*

#### VOLUSIA COUNTY MEDICAL SOCIETY

The Volusia County Medical Society held its annual meeting and dinner at the Halifax District Hospital on the evening of December 13. The following officers were selected: president, Dr. Maximilian Stern, Daytona Beach; vice-president, Dr. L. V. L. Brown, DeLand; secretary-treasurer, Dr. R. L. Miller, Daytona Beach.

The scientific program consisted of a talk by Dr. R. D. Thompson of the Florida Tuberculosis Sanatorium, Orlando, who spoke on, and demonstrated with x-rays, the recent advances made in the treatment of tuberculosis and the work being done at the Florida Sanatorium.

\* \* \*

#### WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

The Walton-Okaloosa County Medical Society is the second society in the state to submit its membership roster and dues for 1939, being preceded only by the Pinellas County Medical Society. The new officers of the Walton-Okaloosa County Medical Society are: Dr. A. G. Williams, Lakewood, president; Dr. Rhett E. Enzor, Crestview, vice-president; and Dr. R. B. Spires, DeFuniak Springs, secretary-treasurer.

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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Primary Carcinoma of the Urethra: Report of a Case—MELVIN, PERRY D., Miami, *J. Urol.* 39: 414-417 (April), 1938.**

Primary carcinoma of the urethra is "the rarest of all genito-urinary malignancies." To date only about 250 cases have been reported. They are usually of the squamous cell type. Symptoms will depend on the location of the tumor. In the pendulous portion, the tumor is early manifested. In the deep urethra, diagnosis may be very difficult for symptoms may suggest cystitis, prostatitis, stricture, abscess or fistula. Endoscopy and biopsy should be done in all suspicious conditions, especially if hemorrhagic tendencies are present. As diagnosis is usually late, prognosis is poor and treatment is usually palliative surgery unless the tumor is in the pendulous penis where a radical amputation of penis and dissection of adjacent glands can be done.

An interesting case of such a tumor of the pendulous penis with amputation and dissection of glands is reported.

**The Physiologic Approach to the Correction of Constipation—WELCH, P. B.; and KAUDERS, F. H., Miami, *South. M. J.* 31: 709-715 (July), 1938.**

According to the authors, chronic constipation is to be corrected by three important methods:

(a) Removal of all sources of infection, irritation of viscera, metabolic or allergic disturbances.

(b) Control of the colon contents so as to produce distention without irritation, by means of diets and proper fluid intake.

(c) The initiation of the feeding reflex by frequent, small feedings with proper mastication of food, which with habit time for defecation and elimination of cathartics helps to avoid overloading of stomach, intestines and colon.

The efficacy of these procedures depends on the following conclusions based on the authors' experimental work and hypotheses:

1. The activity of the colon is influenced by

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**OBSTETRICS**—Two-weeks' Intensive Course starting March 13, 1939. Informal Course starting every week.

**FRACTURES AND TRAUMATIC SURGERY**—Informal Course every week; Intensive Ten-day Course starting February 13, 1939.

**OPHTHALMOLOGY**—Two-weeks' Intensive Course starting April 24, 1939. Informal Course starting every week.

**OTOLARYNGOLOGY**—Two-weeks' Intensive Course starting April 10, 1939. Informal Course starting every week.

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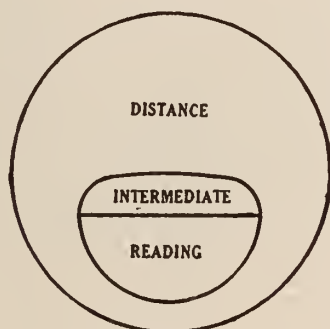
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many factors, intrinsic and extrinsic, especially stimuli from adjacent viscera.

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5. Spastic constipation exists, usually associated with extracolonic visceral disease, especially disease of the genito-urinary tract and anus.

**Paresis: Analysis of 511 Treated Cases,** MATTHEWS, R. A., Philadelphia; BOOKHAMMER, R. S., Norristown, Pa.; and IZLAR, W. H., Miami, *Am. J. Psych.* **94**: 1259-1274 (May), 1938.

The results of treatment of 511 cases of general paresis committed to the Philadelphia Hospital for Mental Disease is given in a statistical study by the authors. With few exceptions these cases were committed from the Psychopathic Division of the Philadelphia General Hospital and constituted a group in which the disease had reached a fairly advanced state. About one-half of these had received fever therapy of some kind and the other half had had very little specific parietic therapy.

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## BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**DRUG ADDICTS ARE HUMAN BEINGS.** By HENRY SMITH WILLIAMS, M.D., B.Sc., LL.D., scientist, biologist, psychiatrist, physician, and author of 119 books.

An expose of bureaucratic disregard of Federal law and defiance of Supreme Court rulings by lower courts, with the result of setting up a billion dollar underworld "racket" of drug smugglers and dope peddlers, and the persecution of 25,000 physicians who have committed no crime. Hypocrisy of Code (which is illegal Federal Narcotics Bureau Regulation), which deprives physician of his rights under Harrison Drug Act of 1914. Appendix contains statement of Narcotics Problem by Hon. John M. Coffee of Washington, reprinted from Congressional Record. Cloth, pp. 273, with illustrations by author; price, \$2.50. Washington, D. C.: Shaw Publishing Company.

**HOW TO CONQUER CONSTIPATION.** By J. F. MONTAGUE, M.D., Medical Director New York Intestinal Sanitarium; Editor in Chief, Health Digest.

This volume, written for the laity, has been arranged in two parts: "The Patient Asks," and "The Doctor Suggests." Fifty points are considered in the first portion of the book, such as "How About Laxatives," "Is It All Right to Take Enemas," "What About Special Diet Systems," "Can Change of Water Cause Constipation," "Does Bran Help," "Is Halitosis Due to Constipation," "What About Yeast," and "Does Overeating Ever Cause Constipation." In the second portion, the author explains how to relieve constipation in infants, older children, children nearing maturity, adults, and elderly people. Other subjects are discussed, such as the sensible use of fruits and vegetables, the value of agar-agar, psyllium seeds, and health foods. Cloth, pp. 244; price, \$1.50. Philadelphia, J. B. Lippincott Co.

**INTERNS' HANDBOOK.** "A Guide, Especially in Emergencies, for the Intern and the Physician in General Practice." By Members of the Faculty of the College of Medicine, Syracuse University; under the Direction of M. S. Dooley, A.B., M.D., Chairman, Publication Committee. Second edition, revised and reset.

The intern is constantly meeting new situations, fraught with possibilities of dangerous mistakes, for which he is ill-prepared. The authors' purpose has been to equip the intern with information for meeting emergencies without either writing a textbook or unwittingly making him a compend addict. Information needed in using standard drugs is given in one section. The contents of the book are divided into five sections under the general headings of "Relationships," "Laboratory Medicine," "Medicine," "Surgery," "Therapy," and "Nursing." Cloth, pp. 523; price, \$3.00. Philadelphia: J. B. Lippincott Co.

**SICKNESS INSURANCE IN EUROPE.** By J. G. CROWN-HART, secretary of State Medical Society of Wisconsin.

A report of Mr. Crownhart's official studies abroad during the spring of 1938, on behalf of the State Medical Society of Wisconsin which includes a comprehensive discussion of such pertinent topics as "Problems of Medicine," "Introduction to Sickness Insurance," "Security and Insurance Aspects," "Benefits and Administration," "The Role of Sickness Insurance Abroad," "Operation of the System in England," "Disease Prevention Aspects Lost," "In Other Countries," and "Measuring Values." Cloth, pp. 134; price, \$1.00. Madison, Wisconsin: Democrat Printing Company.

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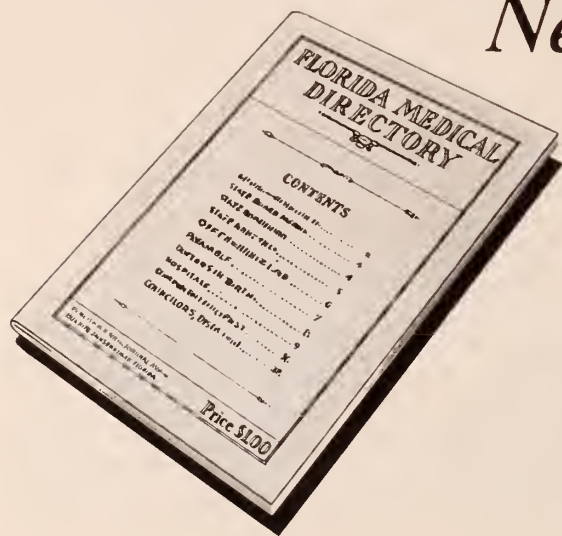
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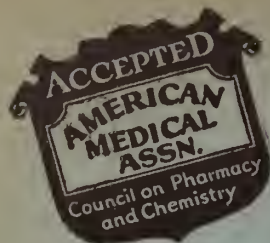
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COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

Dis- tricts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not In- cluded in First Column	Members	
						Total	Paid
Northwest District (A) Marianna, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	11	
	Escambia	J. M. Hoffman, M.D. 1221 E. DeSoto St. Pensacola	J. N. McLane, M.D. 204 W. Brainard St. Pensacola	2nd Tuesday 8:00 P. M.		44	
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	5
	Washington-Holmes	B. W. Dalton, M.D. Vernon	R. H. Segrest, M.D. Bonifay		Santa Rosa	8	
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'39 N. A. Baltzell, M.D. Marianna	7	
	Jackson	D. A. McKinnon, M.D. Marianna	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		14	
	Leon-Gadsden-Liberty- Wakulla-Jefferson	W. W. Massey, M.D. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	36	
North Central District (B) Ocala, 1939	Columbia	W. M. Ives, M.D. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M.D. Lake City	17	
	Madison	E. Long, M.D. Madison				3	
	Taylor	Ralph J. Greene, M.D. Perry	W. J. Baker, M.D. Foley	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton- Lafayette-Suwannee	8	
	Alachua	J. E. Maines, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St. S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	29	
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		21	
	Pasco-Hernando- Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmora, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	9
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	Bradford-Gilchrist- Levy-Union	3	
N. E. District (C) Palatka, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M.D. Jacksonville	168	20
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	11	
	Putnam	Z. Brantley, M.D. Grandin	Allen P. Gurganious, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	10	
	Volusia	Maximilian Stern, M.D. Box 5093 Daytona Beach	R. L. Miller, M.D. 253 1/2 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	38	
Southwest District (D) Lakeland, 1939	Hillsborough	J. W. Alsobrook, M.D. 120 N. Collins St. Plant City	James G. Grable, M.D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M.D. Plant City	104	
	Manatee	S. G. Hollingsworth, M.D. Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.		13	100%
	Pinellas	E. C. MacCordy, M.D. 627 11th St. N. St. Petersburg	W. C. McConnell, M.D. 1005 Equitable Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		89	56
	Sarasota	T. W. Taylor, M.D. Walpole Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	
	DeSoto-Hardee-High- lands-Charlotte- Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. Sebring	2nd Tuesday 8:00 P. M.	D-8-40 Herman Watson, M.D. Lakeland	20	
	Lee	H. Quillian Jones, M.D. 18-20 Leon Bldg. Fort Myers	Harrie J. Stipe, M.D. 39 Earnhardt Bldg. Fort Myers	3rd Friday 7:30 P. M.		13	
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	61	
South Central District (E) Sanford, 1939	Brevard	G. E. Christle, M.D. Titusville	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	12	
	Lake	W. G. DeVane, M.D. Groveland	Terry Bird, M.D. Lake County Health Unit Tavares	1st Thursday 12:30 P. M.		18	
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		76	
	Seminole	Thomas F. McDaniels, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. Box 489 Sanford	2nd Monday 7:00 P. M.	Osceola	13	
	St. Lucie-Okeechobee Indian River-Martin	R. C. Bootbe, M.D. Ft. Pierce	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-39 H. D. Clark, M.D. Ft. Pierce	16	
	Broward	A. B. Connor, M.D. Sweet Bldg. Ft. Lauderdale	Olliver C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	81	
S. E. District (F) W. Palm Beach, 1939	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Harvey Bldg. W. Palm Beach	4th Monday 8:00 P. M.		58	
	Dade	M. Jay Flipse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M.D. Miami Beach	282	
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 0:00 P. M.		4	





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Jacksonville, Florida, February, 1939

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American Medical Association, St. Louis, May 15-19, 1939  
Florida Medical Association, Daytona Beach, May 1, 2, 3, 1939  
Southern Medical Association, Memphis, November 21-24, 1939

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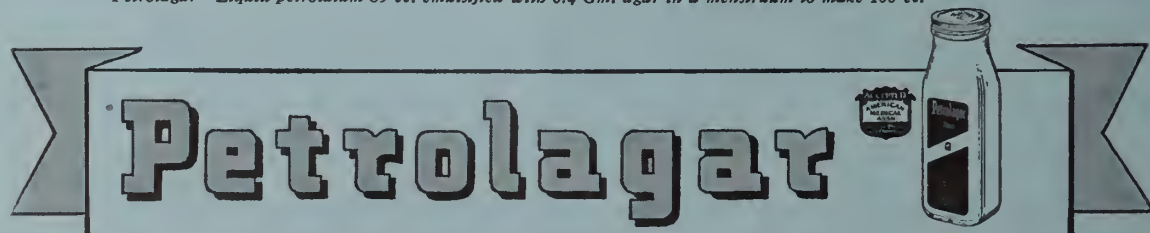
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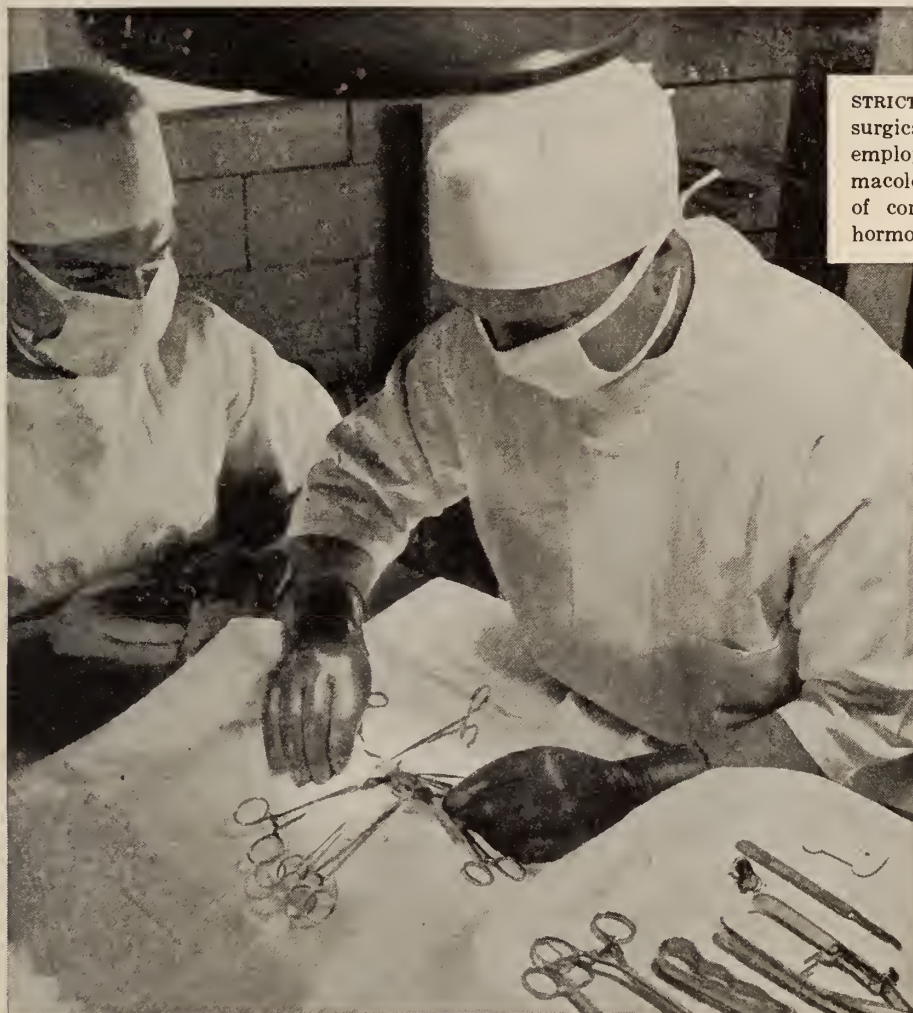
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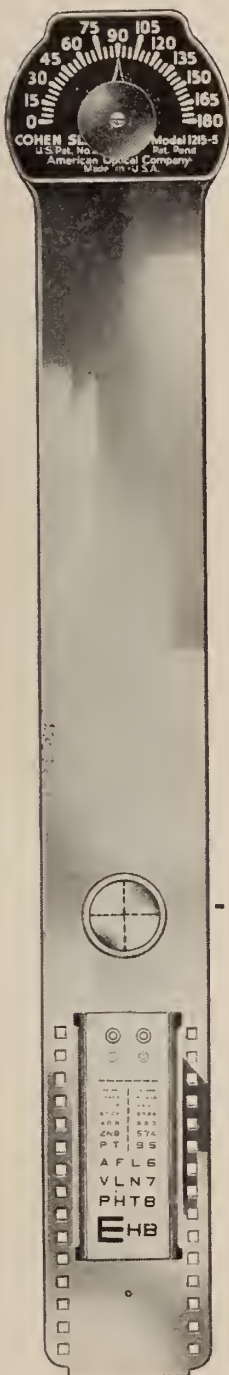


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This discovery is of the most basic importance in the field of vitamin B<sub>1</sub> research. Determination of the chemical nature of this factor permits not only explanation of certain previously known facts concerning vitamin B<sub>1</sub>, but in addition, has opened new fields of research. One of these is already concerned with the development of a reliable chemical method for estimation of thiamin which will be generally applicable to foods.

At present, quantitative determination of vitamin B<sub>1</sub> necessarily requires the use of one of the several bioassay methods available for that purpose. None of these is entirely satisfactory (1, 2). Perfection of a chemical method for quantitative measurement of thiamin in foods would add greatly to our knowledge of its occurrence in nature,

as well as permit more comprehensive studies of factors which might influence the stability of vitamin B<sub>1</sub> in foods. We have a relative paucity of such data relating to vitamin B<sub>1</sub> when the available information on vitamin C is considered.

It should also be stated that the synthesis of thiamin—which is now produced on a commercial basis—has already provided the clinician with a most useful diagnostic tool. Administration of the pure vitamin in cases of suspected thiamin deficiency, with notation of the therapeutic response, constitutes the most trustworthy means of detecting avitaminosis B<sub>1</sub>. After the diagnosis has been confirmed and the immediate deficiency corrected by administration of thiamin, it is desirable that future adequate supply of vitamin B<sub>1</sub> be obtained through dietary readjustments (1).

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- (1) 1938. J. Amer. Med. Assn. 110, 727.  
(2) 1938. Ibid. 111, 927.  
(3)a. 1936. J. Nutrition 11, 383.  
b. 1936. J. Amer. Diet. Assn. 12, 231.

- (4)a. 1932. J. Nutrition 5, 307.  
b. 1932. Ind. Eng. Chem. 24, 457.

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## THE DIAGNOSIS AND TREATMENT OF AMEBIC DYSENTERY

JAMES L. BORLAND, M. D.  
Jacksonville

In this discussion of the diagnosis and management of amebic dysentery, I want to explain at the outset that I use the words "amebic dysentery" loosely to mean a specific infection of the bowel by the protozoa, *Endamoeba histolytica*, and I do not use them to indicate the severity, type of diarrhea, or cellular content of the stool.

The realization that amebic dysentery is not simply a tropical disease but endemic throughout the world has come only in recent years. In the United States, particularly since the Chicago epidemic, we are beginning to realize that it is one of the commonest of the dysenteries. Throughout this country wherever a search has been made for the organism, it has been discovered that at least four per cent of the population have been harboring this parasite. As the tropics are approached, the percentage increases. In Florida, a subtropical region, it must be realized that any diarrhea, however mild or severe, transient or persistent, must be considered a possible amebiasis. There are some differences in the disease in the temperate zone. Here the disease is much less virulent than in the tropics, the complications less frequent, and its management less difficult. I shall try to give you a picture of the disease as it is encountered in this state.

The nature of the parasite, the manner of infection, and its method of producing disease must be considered briefly.

The *Endamoeba histolytica* exists in three forms: the active, motile ameba or the trophozoite; the precyst; and the cyst. The trophozoite is the disease-producing, tissue-invasive stage and is the only form found within the tissues. Its chief weapon against the tissues of the host is a cytolytic toxin which dissolves both tissues and blood cells. By certain changes in the nuclear structures, storage of glycogen, and the acquisition of a thick,

tough cell membrane, the trophozoite passes through the precystic stage to the cyst. This latter is the only form of the organism which is capable of sustained existence outside of the host or of infecting another animal. Cysts are formed only in the lumen of the gut and can not damage the host. No competent observer has ever seen cysts in the tissues. The conditions which cause cyst formation are unknown, but it is certain that cysts are found only in formed stools; so, presumably, change in environmental moisture is the predominant factor.

The manner of infection is by ingestion of the cyst in food or water, passage of the cell, protected by the membrane, through the stomach without harm and down the intestinal tract to the region of the cecum, where the proper moisture, warmth, and other conditions for growth are present. Here the cyst form breaks up into trophozoites. The trophozoite, coming into contact with the intestinal wall, by means of the cytolytic toxin literally dissolves a pathway through which it penetrates the mucosa and reaches the submucosa. Here it forms the typical flask-shaped ulcer with the neck extending up through the mucosa to the surface.

An infection by the *Endamoeba histolytica* is essentially a local disease. The toxin is one which, to a large extent, acts locally and apparently produces little systemic or toxic reaction. Lesions within the intestinal tract or elsewhere in the body depend on the presence of the *Endamoeba histolytica* at that point. Any generalized systemic reaction is probably due to the absorption of necrotic tissue, although it is possible in cases of overwhelming infection that the toxin may be absorbed in sufficient quantity to manifest itself generally.

The characteristic pathology, therefore, of amebic dysentery consists of multiple necrotic abscesses, with little inflammatory reaction in the intervening tissues, localized to one or more segments of the large bowel. This localization occurs most frequently in the cecum, less frequently in the rectum, occasionally in both, and rarely through the entire colon.

The symptoms, physical findings, and laboratory problems are readily understood if the

fundamental pathology is borne in mind. The patient with amebic infection, except in unusually severe cases, complains chiefly of disturbance within the large bowel and his symptoms are those of any localized large bowel lesion. He is troubled with a moderate intermittent diarrhea with little tenesmus but with mild, colicky abdominal pains. There is, as a rule, little fever. He complains of malaise and has the various vague symptoms, probably nervous in origin, which are common to chronic inflammatory bowel lesions. One of the most persistent of these symptoms is an intermittent dizziness. There is usually tenderness in the abdomen, sharply localized to whichever area is involved. The blood studies are consistent with a non-pyogenic infection. The blood count is slightly elevated and frequently has a predominance of lymphocytes. The eosinophilic count is rarely elevated. The patient may or may not have anemia, and even an elevation of his hemoglobin and red count, particularly in mild cases, may be found.

During the periods of diarrhea the stools are characteristically large, brown, and foul in odor. Occasionally they contain mucus and blood. As Manson expresses it, amebic dysentery is "walking dysentery" as opposed to the "lying down" or bacillary dysentery, which has as its distinguishing features toxicity, generalized abdominal pain, marked tenesmus, and small, frequent, odorless, purulent, acid stools. Visualization of the bowel through the proctoscope in bacillary dysentery shows widespread, generalized inflammation of the rectum and sigmoid with small, superficial, coalescing ulcers. These ulcers are ragged, their edges are undermined, and they are distributed transversely to the long axis of the gut. In amebic dysentery, if present in the rectum, the ulcers are oval, deep, and irregular, with obvious necrosis in the base; they tend to lie in the long axis of the bowel. The intervening mucosa is less involved than in bacillary infection because of the lack of an inflammatory toxin.

In periods of acute exacerbation, bacillary dysentery can be definitely ruled out by a study of the clinical picture and stool. This latter can not be emphasized too strongly. The gross characteristics of the stool have been previously described. Clinicians untrained in pro-

tozoology should have little difficulty in rapidly establishing the likelihood of bacillary dysentery by a microscopic study of the stool. In this type of dysentery, the stool is definitely purulent with a large number of polymorphonuclear leukocytes and blood. The cells are toxic in type and show nuclear degeneration. Frequently there is only a slight rim of cytoplasm—the so-called ghost cells. In addition, macrophages, ameboid body cells, are present in great numbers and are difficult to differentiate from amebae. They are, however, the characteristic response to bacillary infection. These cells may contain red blood cells and have pseudopods, thus rendering the diagnosis even more difficult.

In amebic dysentery the cytologic picture is distinctive. There are generally few cells present. The white blood cells which are present are usually mononuclear. As a rule, there are red blood cells and desquamated epithelial cells. The importance of the latter is considerable, as they are found whenever mucus is present in the stool, regardless of the cause, and are frequently confused with amebae. In a large percentage of cases, elongated, slightly triangular Charcot-Leyden crystals are seen. These usually, though not always, signify a parasitic infection and should not be overlooked. One other distinguishing feature of the cellular exudate is that, as a result of the lytic action of the amebic secretion, the cells are eroded from the periphery, and nuclei which have been divested of their cytoplasm are seen.

The treatment of a patient on a presumptive diagnosis of amebiasis is unjustified except as a last resort. If the bowel disorder is not of amebic origin, the use of highly irritant or toxic amebaicidal drugs may seriously increase the patient's ailment or jeopardize his life. After bacillary dysentery has been excluded, numerous possible causes of the disorder remain. The microscopic elements of the amebic stool are suggestive but not pathognomic, and the presence of the *Endamoeba histolytica* must be established before treatment is begun for the same reason that the presence of the malaria plasmodium must be definitely proved before specific therapeutics are instituted.

There are five known amebae which commonly inhabit the intestinal tract: *Iodamoeba buetschlii*, *Dientamoeba fragilis*, *Endolimax*



nana, *Endamoeba coli*, and *Endamoeba histolytica*. Of all these, the *Endamoeba histolytica* alone is generally accepted as capable of producing dysentery. The incidence of the innocent amebae, particularly in Florida, is such that in any diarrheal case, one or more of these organisms is likely to be found. Contrary to the general belief, the *Endolimax nana* and *Endamoeba coli* are very motile; therefore, a motile ameba in the stool is not necessarily *Endamoeba histolytica*. Further differentiation is needed before the diagnosis can be made. At times this differentiation, even in the most expert hands, is impossible.

Difficulty in locating the *Endamoeba histolytica* may be experienced even in acute dysentery and certainly in the milder stages of amebiasis. This is probably due to two factors: first, the involvement is generally in the cecum, and the *Endamoeba histolytica* is destroyed before it reaches the exterior, the destruction probably occurring in the rectum; second, the *Endamoeba histolytica* in some cases appears intermittently, possibly as a result of the rupture of one or many of the ulcers and the sudden liberation of amebae which had hitherto been trapped by the bottleneck outlet.

If direct examination of the feces is negative, one must then resort to concentration methods, the technique of which is not within the scope of this paper, or attempt to get material from higher up in the bowel before the protozoa are destroyed. This latter can be done by swabbing the ulcerated areas, by lavaging the terminal sigmoid through the sigmoidoscope, or by using a purge. If a purge is given, the specimen should be examined the following day, as occasionally amebae can be found only on this day; their appearance at this time is probably due to the fact that the ulcers are broken down by the purge. However, a purge should be employed as a last resort, since catharsis in an already inflamed bowel sometimes produces an increase in inflammation which persists for some months. It should be thoroughly understood that there is no substitute for repeated daily examinations and that sometimes even by utilizing concentration methods, purges, and examination of material obtained through the sigmoidoscope, a diagnosis can not be established until after ten or fifteen examinations.

Cultural methods are relatively efficient, and a few cases can be diagnosed only by this method. There are various media in use. In my own laboratory we are at present using Tanabe Chiba media. In recent years there has been devised a complement fixation test for amebiasis. In certain hands it has proved extremely accurate and occasionally will reveal the odd case which repeated examination and cultural methods can not disclose. In most laboratories it appears to be erratic and uncertain. In the future, however, it may play an increasingly important role in the diagnosis of amebic dysentery.

The treatment of amebic dysentery may be divided into two stages: (1) immediate measures directed toward stopping an acute infection of the bowel and destroying the majority of the organisms, and (2) measures directed toward completely ridding the body of parasites and cleaning up the residual damage, or in other words: (1) the immediate treatment and (2) the long-term regime.

Fortunately, specific drugs for the treatment of amebic dysentery are available. In fact, the practitioner is confronted with a bewildering array of possible drugs and is often uncertain which he will utilize. For all practical purposes, in this country, these fall into three groups: the alkaloids of ipecac, i. e., compounds of emetine; the drugs which depend for their action on the liberation of arsenic; and the drugs which liberate iodine. In choosing the drug, it is best to abandon exact pathology and pharmacology and to think in the following terms: It is easier to determine the type of treatment necessary if one considers that, in any amebic infection, there are two problems in killing the amebae: the destruction of those deep in the tissues, and the destruction of those free in the bowel or superficial in the mucosa. It is helpful to decide whether there is deep involvement before selecting the drugs to use and determining the time to use each particular drug.

Ipecac and its derivatives are the drugs par excellence for killing amebae in the tissues. Ipecac, although probably the most efficacious drug available, is rarely used now, as it is somewhat heroic treatment and the administration is inconvenient. Emetine is the only one of the alkaloids of ipecac which is in common use. Emetine is toxic to amebae in quite

high dilutions, a solution of one part in twenty-five thousand being sufficient to kill amebae in vitro. Presumably, it is secreted into the intestinal contents in such low dilutions that it does not kill organisms living in the lumen of the gut or superficially in the mucosa. This drug is available in two forms. It may be given hypodermically as the hydrochloride, or it may be taken by mouth as emetine bismuth iodide. One can not repeat too frequently the warning concerning the toxicity of emetine. It is a general protoplasmic poison with a specific effect on muscle. Its most dangerous action is the deterioration of the heart muscle so that death from syncope has sometimes occurred in the past. There is some question as to whether a true peripheral neuritis occurs from emetine despite the fact that this is the diagnosis attached to the palsies which occur in emetine poisoning. There is probably no danger except in rare cases of idiosyncrasy or in cases in which there is a pre-existing cardiac condition or kidney damage, provided a dose in excess of 10 grains is not used. For individuals who are of very slight build or who are wasted, a dose of much less than this should be considered maximum. The hydrochloride should be given in doses of 1 grain a day until the desired effect or maximum dose is reached. Some men routinely use emetine, proceeding on the theory that it protects the liver. I believe that most patients are benefited by the administration of some emetine at the beginning of the treatment, even if it is only 3 or 4 grains.

In order to rid the patient completely of infection, it is necessary to kill the amebae in the intestinal contents, and the use of one or more of the group of drugs is required. Acetarson, treparsol, and carbarsone comprise one group. This class derives its efficacy from the liberation of arsenic and its excretion along the intestinal wall and into the intestinal contents but has the disadvantage attendant upon any arsenical preparation; i. e., gastro-intestinal irritation. There have been reports of arsenic poisoning, the symptoms of which I need not go into here. Of all, carbarsone is the least toxic. Concerning this latter, Craig warns that it has an amino group in the para position; therefore, one must beware of possible optic atrophy. Arsenicals have the

advantage of killing almost all the protozoa which infest the bowel (and usually there are other parasites in association); but the drugs which depend for their action on the liberation of iodine apparently do not affect any but the histolytica.

The oxyquinoline derivative group, the action of which depends upon the liberation of iodine, is the other class of drugs useful in killing amebae in the intestinal contents. These are chinofon—more commonly known as yatren or anayodin—vioform, and the new drug, diiodoquin. They increase in iodine content in the order given. Presumably, if iodine is the amebicide, their effectiveness should also increase in that order, but this does not seem to hold true. Yatren has been most thoroughly tried, has been widely proved to be effective, and is practically nontoxic. It does, however, irritate the intestinal wall more than the other two so that the symptoms are frequently aggravated and, if diarrhea is not present, it is almost always produced by the yatren. The irritation seems to be transient and disappears when the drug is no longer administered; so unless the diarrhea becomes debilitating, the dosage need not be reduced. Patients who are taking vioform very often complain of weakness and general malaise, particularly after a second course. I have seen several amebic recurrences in patients for whom I prescribed vioform. Diiodoquin has not yet had sufficient trial for final evaluation.

Bismuth subnitrate has been used for a long time in the treatment of amebic dysentery. Doctor James and his associates used it almost exclusively, either alone or in conjunction with emetine, and have reported excellent results. Other observers have reported a large percentage of recurrences with the use of bismuth alone. It is not known whether bismuth subnitrate definitely attacks the amebae or whether, by acting on the intestinal content, renders it unsuitable for amebae for long periods following its administration. It is useful as a supplement following a course of one of the amebicidal drugs for three purposes: to remove the few remaining amebae or, at least, to prevent their multiplication; to reduce by means of its mild antiseptic action the total number of bacteria in the bowel; and to utilize its healing effect on the ulcerated areas.



The main problem in the treatment of amebic dysentery is not in the first course of treatment, as it is relatively easy to relieve the dysentery and get rid of most of the organisms except in chronic cases; the difficulty comes with the subsequent course. There is no disease in which careful and accurate laboratory work by trained observers is more essential to the proper management of treatment after the initial stage has been passed. Symptomatology is not the criterion for specific therapy. Following the original course, the feces are examined to determine whether histolytic amebae or cysts can still be demonstrated. Patients with acute dysentery often stop the diarrhea immediately, gain weight, lose all subjective symptoms, but continue to pass cysts in their stools as a sign that they are still infected. These patients must be repeatedly treated and carefully checked over a long period of time for amebic cysts, for, although symptoms have disappeared, they may recur at any time or one of the other dreaded complications may develop. It is because of this persistence of infection that we find use for the wide variety of drugs with amebicidal properties. No one drug seems to be effective in all cases, and one should not continue to use the same drug but should change from one group to another or from one to other drugs within the same group. The diarrhea may persist, but it is more frequently noted that, when symptoms cease and the patient begins to be active and reverts to his original diet, the diarrhea recurs, although *Endamoeba histolytica* has never been demonstrated. It is a great mistake to add a highly irritant drug when the symptomatology is due to a nonspecific irritation and secondary infection of the bowel. It is common experience in this field to find patients completely debilitated by toxicity of anti-amebic treatment administered by a physician who believes he is still dealing with a specific infection.

It is impossible in the short period of time allotted to do more than sketch the major points of the diagnosis and treatment of this infection. I have, in the discussion of the treatment, merely touched on the more technical phase. It must be realized that the general measures are equally important in acute dysentery, in the milder cases, and in the convalescent period. There seems to be no neces-

sity to list such measures as proper fluid management, diet, rest, and sedation. It does seem advisable to mention, however, that, as in almost all other infections of the gastrointestinal tract, patients who have suffered from amebic infection must be under care, observation, and restriction for long periods of time. Of all the therapeutic aids, aside from specific drugs, none is more important and necessary than rest.

It is becoming obvious that infection by the *Endamoeba histolytica* is a serious health problem and that this disease has been insufficiently emphasized in the teaching institutions and hospitals of this country with the result that it has not assumed the place in present day medical thought that its prevalence and severity warrant.

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*207 Medical Arts Building.*

#### DISCUSSION

*Dr. W. McL. Shaw, Jacksonville:*

It has been my privilege to examine a series of these cases with Doctor Borland from the standpoint of the roentgenologist. Doctor Borland mentioned that this disease was rather forcibly brought to the attention of the country a year or two ago by the epidemic in Chicago at the World's Fair, at which time they had over 1400 cases.

We do not think that the x-ray barium enema examination is pathognomic of anything typical in amebic dysentery; that is, we do not think that we can differentiate and say that it is amebic dysentery or that it is not amebic dysentery by use of the barium enema. There are certain changes that occur in the bowel that we feel are best brought out and shown by the use of the barium enema, and we have found certain parts of the bowel which seem to be infected or to break down with the infection or the invasion over other parts. I have a few slides which bring out this point.

We feel that the simple barium enema is the best method of examining these cases. There are several other methods of examining the colon with enemas but most of them are long drawn out, often quite painful to the patient, and the findings are rather indefinite. The plain barium enema as mixed with malted milk and given by the doctor under fluoroscopic control is the best method of bringing out the weak points in these colons. It should be given as above mentioned under fluoroscopic control, turning the patient from time to time to prevent overlapping of parts of the bowel. Sometimes we stop and make films before the bowel is completely filled. The head of the column of barium should be kept under constant observation under the fluoroscope because that is where things usually happen. The bowel will contract down rather suddenly if the barium rushes in and if you are not looking you will miss it. We have found most of the changes in the sigmoid or cecum. We had one case in November when the changes were predominant in the cecum, and the following February the cecum looked relatively normal but the sigmoid was badly involved.

#### SLIDES

This represents the examination made in November on a patient in West Florida about 48 years of age with symptoms of dysentery over several years duration. This represents the first film made immediately after



injection showing a smooth sigmoid and spasm just above the cecum. There was slight dilatation of the cecum and tendency for contraction or spasm at the head of the cecum. We have found that to be one of the characteristic signs. The lower end of the cecum is sometimes like an inverted funnel.

This film represents the condition immediately after expelling the enema. You notice a deformity of the lower end of the cecum, and smoothness from here to the rectum, all of which indicates irritability of the bowel. We were rather concerned about this at the time because there was some blood in the stool. We questioned whether that might not be a neoplasm. This examination was made in November. Her next examination was in February and the cecum was still large, but most of the changes were in the sigmoid this time.

This represents the film after expulsion.

We have noted also that in these cases we often get an extensive leak into the terminal ileum. The valve seems to be rather incompetent.

This represents the patient after injection, and this after expulsion. (Demonstrating.)

This case showed a positive organism. The patient returned to her West Florida home for treatment and we do not know the results of this treatment yet.

Next case: This is a white woman 28 years old. She had a baby about one month old when this work was done. She was having many stools. There were marked intermittent spasms and relaxation of the bowel. She had a smooth sigmoid without haustration. The cecum was contracted with spasm above it. This was very painful on pressure. This represents the film immediately after expulsion and you see a large residue.

### *Dr. Ralph N. Greene, Coral Gables:*

I wish to justify my position as a neurologist in the discussion of this paper. Neurologists have for a long time been interested because we so frequently encounter midbrain pathology with severe gastro-intestinal lesions; perhaps trophic in origin.

It has been my privilege to have observed protozoological research in the field of aviation medicine. A large group of pilots whose activities have taken them almost over the entire globe, is centralized more or less in the City of Miami. These men have been under constant medical supervision, every six months, for a period of ten or more years.

When suspicion arose as to protozoa and their effect on the health of these pilots, it was found that in one group of pilots, 60 per cent were infected with some form of protozoa. In another group of pilots, 30 per cent had protozoan infections of various kinds. In the first group of fifty pilots, twenty of them had amebic dysentery. In the other group only four cases of active amebic histolytica have been demonstrated.

There were two doctors in attendance at this meeting who have been chronically victims of amebic dysentery, the lesion long unrecognized, yet the persons were battling against vague symptoms. It is interesting to note that in 35 per cent of the cases of amebic dysentery, the patients do not experience symptoms.

From the viewpoint of aviation medicine, we are impressed with the fact that some of these pilots would deny vertigo while in the sitting position operating the controls of the airplane but, on standing, would become dizzy.

I was impressed also as the result of a recent conversation with Dr. Charles Wardell Stiles, probably the most outstanding authority in the field of protozoology wherein he stated that there is only one lay technician in the United States upon whose opinion he would rely for a diagnosis of these various dysenteries. It is my impression we should not rely too implicitly upon diagnoses of technicians. There are few doctors who are capable of making these dysentery diagnoses. We should be deeply concerned about the dysentery patient's health because, eventually he is going to become incapacitated, with a possible amebic abscess of the liver. Abscess of the liver from amebic dysentery will probably not require surgical intervention as was formerly a routine

procedure. It may be treated by the administration of emetine, a dangerous drug which should only be given in a hospital under strict medical supervision.

Amebic dysentery is a widespread infection. According to Craig, from five to twelve million people in the United States have had amebic dysentery. In a Chicago hotel epidemic, out of 200 cases, 19 are known to have died and the fate of others is unknown.

I would like to mention to you also that if one has a patient bleeding from the lung, from a bronchial glaucoma, that it is well to consider the possibility of *Endamoeba histolytica* infection. Lung invasion seems possible.

Dr. Steward Roberts of Atlanta recently stated to me that it is his belief that amebiasis is one of the most widespread of all human ailments.

### *Dr. Marvin Smith, Miami:*

I arise, Mr. Chairman and Members, to commend Dr. Borland for his fine essay, and to congratulate him upon his courage in presenting to us another piece of valuable literature on amebic infection. Every week sees the addition of more data on this important entity in medicine.

Ulcerative colitis, which is the gross pathology produced by amebic infestation, in my opinion, is one of the most serious of all maladies from which the human family suffers. Ulcers in the colon may come from other sources but when *Endamoeba histolytica* is the cause, both the patient and the physician face an ordeal that will test the former's strength and endurance and the latter's skill and ability.

When I began the practice of medicine in Florida twenty-five years ago I did not think that amebic dysentery amounted to very much. The Doctor then went along quietly treating the patient and hoping from day to day he would get better, and some did, but in too many instances he stood helplessly by and watched the roses fade from his patient's cheek; he witnessed the patient's weakness growing hour by hour; and he saw the blood continue to gush from that bowel in the face of all the treatment that he could give. And, ladies and gentlemen, I want to remind you that we still have before us that same picture, notwithstanding the fact that some improvement has been made in the management of these cases.

Two years ago it was my pleasure to study this subject in Cairo, Egypt and Southwestern Asia. In Egypt I was told that many cases of ulcerative colitis from all over Africa were sent to Cairo for treatment, and the Doctors there say that undoubtedly amebic infestation is the etiological factor in most of the colitis patients. From the mud flats over the Nile valley region it takes the tribes just like measles goes through the public schools in this country.

Members of the Association, this is as important a subject, I feel, as could be presented to you for your consideration. I must respectfully disagree, however, with Doctor Borland about amebic dysentery not being especially inclined to produce free bleeding. For twenty-five years I have treated amebic dysentery in this State and, in my experience, bleeding is one of the most outstanding symptoms, while, on the other hand, my cases of bacillary dysentery have not shown such a copious hemorrhage but greater frequency of movements.

Since every case of ulcerative colitis presents grave possibilities and since an exact diagnosis as to causation is of vital importance, quick measures must be taken to arrive at definite conclusions. Do two things: begin the microscopic search for live ameba and plate out at the same time a fecal specimen on Endo's medium. The appearance of whitish colonies will tell us whether a dysentery bacillus is present or not.

The serious complication in amebic dysentery cases is that after the ameba is destroyed the ulcers in the colon frequently persist and continue to bleed until death.

A laboratory search for secondary invaders will usually reward the doctor by proving to him that the ulceration is being kept up by a streptococcus viridans or a diplococcus or an anerobe which is thriving in

the ulcerations. The successful treatment of either of these depends upon the preparation and proper administration of a vaccine and an antiviral and washed oxygen introduced into the colon.

I employ a special device for collecting material from the bowels for examination; time does not permit a description of it on this occasion.

*Dr. James L. Borland (Concluding):*

I would like to thank Doctors Shaw, Greene, and Smith for their discussions.

I want to thank Doctor Greene for bringing out the question of amebiasis of the liver. We know now that it is necessary to recognize as rapidly as possible the presence or absence of hepatitis in these patients, since emetine is an absolute specific for hepatitis and prevents abscess formation. Even though abscess formation has already occurred, emetine alone is curative in a certain number of cases.

I would like to emphasize especially that we are dealing with a widespread infection which we must seriously consider as a possible cause in any case of diarrhea in Florida, that the diagnosis must be established before therapy is begun, and that this diagnosis requires specific technical training.

## DISTURBANCES OF CARDIAC RHYTHM\*

S. MARION SALLEY, M. D.,  
Miami.

It is the purpose of this paper to discuss, from the clinical standpoint, the diagnosis and treatment of a few of the more common and important disturbances of cardiac rhythm. The subject is a broad one and no attempt will be made to cover more than certain salient points of established clinical value.

Dr. James McKenzie<sup>1</sup> once said: "The eventual use of machines in diagnosis is to teach us how to do without them." The electrocardiograph is no exception to this. Most of our knowledge in the clinical diagnosis of abnormal cardiac rhythms has been acquired through the use of the electrocardiograph.

Before discussing the clinical characteristics of these disorders it is well to emphasize the importance of ascertaining the exact rate of the heart beat when an abnormal rhythm is suspected. It was once thought that a rate of 180 was too fast to be counted. It is now known that a rate as high as 250 can be accurately counted to the beat by the average intern. Accurate counting may be facilitated by keeping time with the foot or the finger and in cases of extremely rapid rates by counting in brackets of ten. Since many of these arrhythmias have a fixed rate it is of great im-

portance to know and compare the rates after a lapse of time or after the patient has been put through maneuvers which ordinarily change the rate.

### SINO-AURICULAR NODE ARRHYTHMIAS

The only disturbances of clinical importance arising in the pace-maker are sinus arrhythmia, normal tachycardia and normal bradycardia. These are mentioned only in passing. Certain others such as nodal tachycardia are rare and cannot be diagnosed clinically.

### AURICULAR ARRHYTHMIAS

Of disturbances arising from ectopic impulses in the auricle the most important, from the clinical standpoint, are paroxysmal auricular tachycardia, paroxysmal auricular flutter, and paroxysmal auricular fibrillation. (For the sake of brevity the word paroxysmal will not be used further in discussing these conditions).

AURICULAR TACHYCARDIA is the most common of these disorders and occurs more often in patients without heart disease than in those with it. Because all of the auricular beats are followed by ventricular beats, the apex rate is very rapid. It is usually between 160 and 250, although I have seen one case in which it was as low as 116. The rhythm and rate are perfectly regular during the paroxysm. If, for example, a patient is seen in an attack with a rate of 176 and is seen twenty minutes later the rate will still be 176. The beats occur at precise intervals. These attacks begin abruptly, frequently after a simple movement as turning the head or stooping over, or on sudden emotion. They end just as abruptly. They usually last seconds, minutes or hours as contrasted with auricular flutter which usually lasts hours, days, or weeks.

The amount of harm received by the patient in these paroxysms depends on the duration of the attack, the rate during the attack, and the condition of the heart before the attack. In most cases no harm is suffered, but a patient with organic heart disease may become decompensated and may appear, on first sight, to be a decompensated "cardiac" with a normal tachycardia. If the attack persists long enough, a thrombosis of one or more of the peripheral arteries may develop. On the whole, however, there is no other condition in which

\*Read before the Sixty-fifth Annual Meeting of the Florida Medical Association, held at Miami, May 9, 10, and 11, 1938.



the heart rate can be so rapid with such little apparent embarrassment to the circulation. A slight fever and leukocytoses are common features and are probably the result of congestion or of thromboses of small vessels.

In about fifty per cent of these cases it is possible to stop the attack by carotid sinus pressure (only one carotid should be used at a time), by firm pressure over the eye ball, by having the patient vomit, hold his breath, or by having him drink a glass of ice-water. In certain sensitive individuals a small dose of morphine may be of assistance when there is difficulty in applying pressure over the carotid artery. Auscultation over the precordium when these measures are tried will reveal either no change whatever in the heart beat or the rate will instantaneously drop to normal. If the latter occurs, the diagnosis is established, for it can be nothing else but auricular tachycardia. When these methods have failed quinidine may be used beginning with a dose of 3 grains three or four times a day and gradually increasing to not more than  $7\frac{1}{2}$  grains four times a day. Acetyl-choline has been used in recent years with some success. The average dose is 15 to 30 milligrams subcutaneously. It should be used with caution and a syringe of atropine 1/100 of a grain should be kept at hand for intravenous use in case of a severe reaction. Acetyl-choline is a powerful vagal stimulator while atropine removes vagal effects. It is not the amount of atropine that counts so much as the promptness with which it is given. Prostigmin plus acetyl-choline holds promise of being still more effective than acetyl-choline alone.<sup>2</sup> For recurrent attacks digitalis or quinidine may be given for an indefinite period of time. Both are effective in preventing attacks.

AURICULAR FLUTTER is another important disturbance of rhythm arising from an ectopic focus in the auricular wall. It generally occurs in patients with organic heart disease, Lewis and his co-workers<sup>3</sup> have demonstrated rather conclusively that flutter is caused by a circus movement of contraction in the auricular wall, which movement is perfectly straight in its course. All the muscle bundles have recovered from their refractory period in time to continue the impulse in regular time intervals. This is in contrast to auricular

fibrillation where the course of contraction is tortuous and irregular. In flutter the rhythm is absolutely regular and the auricular rate is very rapid, generally between 250 and 350 per minute. However, the ventricular rate is generally one-half to one-fourth this fast and auscultation over the heart reveals a rate of 130 to 170 or even as low as 70 or 80. This is because only every other beat or every fourth beat is coming through from auricle to ventricle. The flutter waves from the auricle can occasionally be seen in the neck veins, on the right side of the neck as a rule, and thus establish the diagnosis. Carotid pressure in cases of auricular flutter will not stop the attack but there will be a definite slowing of the rate which immediately returns to its fixed, rapid beat on release of pressure.

In the diagnosis of disorders of rhythm such as these, it is well to have the patient change position and if the tachycardia is a normal one the rate will probably change. If the rate does not change, then carotid sinus pressure (over the bulge of the carotid near the angle of the jaw) should be tried. If this causes absolutely no change in rate, then auricular tachycardia is suspected and if it drops instantly to normal, it is proved. However, if it slows somewhat and continues again at a rapid, constant rate, it is probably auricular flutter.

In certain cases of flutter where the patient has been treated with digitalis and the ventricular rate has been brought down to normal, it is hard to diagnose without the aid of the electrocardiograph. At other times the ventricular beats may be coming through irregularly when the flutter ratio is changing and may thus simulate auricular fibrillation. By keeping time with the foot, however, the time between beats may be found to be quite regularly spaced and this may give the clue.

In the treatment of auricular flutter when no emergency measures are called for, it is best to digitalize the patient and when this has been accomplished digitalis should be stopped entirely. In about thirty per cent of cases the auricular contractions will change from flutter into fibrillation and from fibrillation into a normal rhythm within a day or two.

If this does not occur then quinidine may be given and in these cases quinidine is some-



times necessary in doses high enough to produce toxic symptoms. It will have no direct effect on the ventricle itself but it will slow the auricular rate and frequently restore it to normal rhythm, thereby restoring the ventricle to normal rhythm also. Quinidine acts by lengthening the refractory period of the auricular musculature so that when the wave completes its circuit the refractory muscle stops it. At times, however, quinidine slows the speed of the impulse to such a degree that by the time the wave has completed its circuit the refractory period of the muscle is over and the circus movement continues.<sup>8</sup>

AURICULAR FIBRILLATION is the most important disturbance of cardiac rhythm. It is very common both in the paroxysmal and the chronic form. Its commonest causes are mitral stenosis, myocardial disease, and hyperthyroidism. However, a transient fibrillation occurs in many of the acute infections and in many conditions which do not have any definite relation to the heart. Moreover, it occurs not infrequently in individuals who apparently have no heart disease.

The auricles do not contract in fibrillation and may remain uncontracted for years. A condition of fibrillary twitching exists and is due to an irregular circus movement which pursues a tortuous course through the auricular musculature due to variations in the refractory period of the muscle bundles. The ventricles respond to varied and occasional beats and become grossly irregular in their contractions. Most untreated cases have a rapid rate at the apex, usually from 140 to 180. The pulse rate is very misleading because so many beats do not come through to the wrist.

The disturbance of rhythm most commonly confused with auricular fibrillation is the occurrence of runs of frequent extra systoles. The one important point of differentiation between the two is the constant occurrence of the quick beat of an extra systole before every long pause in a run of premature beats. In fibrillation, however, there are many pauses which are not preceded by a quick beat. Prolonged auscultation will usually be sufficient to rule out premature beats but occasionally it can be very difficult.

The treatment of auricular fibrillation of

long standing and with much underlying pathology, such as an old case of mitral stenosis, is simple. No attempt is made to restore the normal rhythm; the patient is simply digitalized and treated as a chronic "cardiac" case. When the case has possibilities of great improvement through the restoration of normal rhythm and the fibrillation is of short duration, the choice is again a simple one. Quinidine should be given in a definite effort to restore normal rhythm. Many cases are seen, however, which are not so simple, for example, in a thyroidectomized patient where there is little underlying pathology and the arrhythmia is of long duration. The risk of dislodging a mural thrombus when a long inactive auricular wall begins to beat again is quite a real one. On the other hand, if the return to normal rhythm is accomplished without damage the patient may live ten or fifteen years longer than he otherwise would. A recent case report showed a complete return to normal including the return of the heart to normal size in a man who had been fibrillating and moderately decompensated for five years. Each case must, therefore, stand on its own merits when the question of treatment arises and all factors carefully considered.

When digitalis is necessary to treat decompensation there is a difference of opinion as to whether quinidine should be given before or after digitalization. Because a digitalized patient seldom returns to normal rhythm spontaneously and since certain individuals develop fibrillation when they become digitalized, it is the present practice of the writer to use quinidine first whenever possible.

After a case has been restored to normal rhythm it is well to continue small doses of quinidine over a long period of time in order to prevent a return to an abnormal rhythm.

#### VENTRICULAR ARRHYTHMIAS

The only disturbance of great clinical importance arising from an ectopic focus in the ventricular musculature is paroxysmal ventricular tachycardia.

VENTRICULAR TACHYCARDIA. In this condition the beats arise from some focus in the ventricular musculature, and they probably follow a circus movement. The auricles contract at a different rate or follow the contrac-

tion of the ventricle which dominates the rhythm. In almost all cases ventricular tachycardia occurs in cases of severe heart disease and is most often associated with coronary thrombosis. There is almost no other condition that will cause a sudden rate of 190 to 200 at the apex in coronary thrombosis.

The bedside diagnosis is of the utmost importance in this particular disturbance of rhythm because prompt treatment is often life-saving. The important point of first consideration is the occurrence of occasional irregularities in rhythm;<sup>6</sup> secondly, the first sound changes in intensity and quality; thirdly, the jugular pulse is slightly slower in rate than the apex; finally, vagal stimulation has no effect on the rhythm or rate.

Treatment is limited to quinidine which is almost specific in these cases.<sup>4</sup> Digitalis is harmful and may increase the heart rate and prolong the attack. It is definitely contraindicated. Another drug which may hold some promise in these cases where quinidine fails, is atropine. This has not been definitely established but it is conceivable that its vagal inhibitory action might in some cases, allow the auricle to increase its rate and reassume its dominance.<sup>3</sup>

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#### DISCUSSION

*Dr. R. S. Torbett, Tampa:*

Doctor Salley has given us a very good short paper on a large subject. He is correct concerning mechanical aids. We would do better if all used our senses more, then confirmed by means of machines. A regular rapid heart can be counted, an irregular is not so easy.

There is nothing more upsetting to the average person, layman or physician, than an irregularity of rhythm in his or her heart. This is particularly so lately, perhaps due to publicity given heart disease. The most benign change in rhythm is to the patient an occurrence of great magnitude. Nothing that I know of in medicine upsets the patient more and requires greater tact and understanding on the part of the doctor to reassure the patient completely if this is ever done.

Patients want action under these circumstances. It isn't to them a question of being a harmless affliction; relief of attacks is sought and preferably permanent relief.

**AURICULAR TACHYCARDIA.** There is no need for repetition by me. I have seen optic pressure, vagal or carotid sinus pressure—digitalis and quinidine, etc., but in one case I saw, nothing stopped the attack and the patient died.

**AURICULAR FLUTTER.** Due to changing in the block, ratio may be difficult to diagnose from auricular fibrillation. The few patients I have seen all had diseased hearts of a high grade. Treatment given by the essayist is the best, I feel.

**AURICULAR FIBRILLATION.** I must agree with Doctor Salley that quinidine is a wonderful drug but it is very hard to know when to use it. I use it in early fibrillation. In old cases emboli can strike; it isn't just newspaper talk. It happened to me once. A woman's first attack, was digitalized; then I decided to cure her and gave quinidine. She did beautifully but on the fourth day an embolus of the brain paralyzed her.

**VENTRICULAR TACHYCARDIA** is common following coronary thrombosis. Some men even advocate quinidine in all cases to prevent it. The essayist didn't mention premature beats, the commonest of all abnormalities. It means little but over-emphasis and sensation given to the patient make them of great importance. They are due to abnormal stimuli arising in various parts of the heart, and are almost universal. Few of us escape them at some time during life.

**AURICULAR PREMATURE** starts in auricular and spreads in all directions, even ascends sino-auricular node and discharges a normal impulse already in process of development



and interrupting dominant rhythm. The ventricle usually responds to auricular beats but often in an abnormal way.

VENTRICULAR PREMATURE starts right or left and spreads, goes up to auricular ventricular bundle and node but not through it. The direction of the electrocardiograph Q. R. S. depends on the ventricular origin. This is of no clinical significance, however. It occurs in all ages though in males more often than in females. There is no pathology. Auricular is more likely to be due to some cardiac pathology.

Symptoms: The patient is often unaware of them but when conscious of them they cause most patients great mental anguish. Pain at times is felt and often called angina. The electrocardiogram is our most complete diagnostic method.

Causes: Digitalis—tobacco—coffee, etc.

Treatment: If the cause can be found—fine. In most instances, it can't, so we must reassure the patient. All drugs have been tried.

*Dr. Louie Limbaugh, Jacksonville:*

Doctor Salley has thoroughly covered the subject of arrhythmias and I have enjoyed his paper very much. There are, however, a few phases of the subject I would like to discuss.

That a heart rate of 250 can be accurately counted clinically, I think is questionable; a more conservative rate would be 180 to 200.

An arrhythmia that is commonly met is premature beats which may arise from either the auricle or ventricle. The electrocardiogram is the only accurate way of differentiating the two. They do not in themselves mean organic disease. They may be of particular importance where digitalis therapy is being carried out as they may be a manifestation of excessive dosage to the extent of producing a pulsus bigeminus. The electrocardiogram will often aid in this instance by showing other evidences of digitalis effect. Clinical evidence of overdigitalization is difficult at times to determine.

The differential diagnosis of premature beats also concerns partial heart block or drop-beats. This can be done by listening at the apex. Premature beats occur as two quick systoles followed by a pause; whereas, in drop-beats one cardiac cycle is completely absent. The pulse may not reveal the impulse of the premature beat and therefore feel like

a drop-beat of heart block. It should also be mentioned that usually extra-systoles are irregular in occurrence whereas drop-beats occur regularly every second, third or fourth beat.

Ventricular tachycardia deserves emphasis because it means serious heart damage. Following a coronary occlusion the muscle is more irritable and if digitalis is given it may aggravate the tachycardia or be a factor in producing ventricular fibrillation. I feel that for this particular reason, digitalis should not be used in coronary occlusion unless there is definite evidence of congestive heart failure. Even then it must be used with caution, watching closely for any evidence of ventricular tachycardia or increasing numbers of premature beats. Quinidine is often a life-saver in this condition, and it has been suggested as a prophylactic measure. However, I do not use it routinely in the treatment of coronary occlusion.

*Dr. M. A. Kugel, Miami Beach:*

It has been a pleasure to listen to the very instructive talk by Doctor Salley. It is important that he emphasized the value of clinical observation over the total reliance upon mechanical devices.

I have made an intensive study of cardiology although I am not primarily a cardiologist. It has been unfortunate that with the development of the electrocardiographic machine less attention has been paid to the clinical side of cardiology. Originally the electrocardiographic machine was meant as an aid in the investigation of heart disease, but actually what has happened is that these machines have been obtained by poorly trained physicians who have set themselves up to be cardiologists. I have never seen a good cardiologist who was not in the beginning a well-trained physician.

I spent one year in Vienna and Germany and was very much impressed with the training of their doctors in the use of the ordinary senses in pursuing the study of internal medicine. The more knowledge I gain, the more respect I have for the old-fashioned family practitioner. He is the real doctor.

It occurred to me from my observation that although the electrocardiographic machine is very valuable for scientific research it still



does not displace the knowledge of the physician. A machine or a test is merely an aid. The possession of an electrocardiographic machine does not make a cardiologist.

Two things which affect the heart have been overlooked by most physicians. One is the mind and the other is the gastro-intestinal tract. Psychiatry has come to the fore. More and more we realize that coronary thrombosis particularly has an emotional basis. Arrhythmias may be brought on by various gastro-intestinal disorders. Heavy meals will sometimes bring on disturbances in rhythm, tachycardia and premature beats, especially if the patient is allergic. I have seen cases where a patient who had cholecystitis would go into paroxysms of tachycardia and as soon as the gallbladder was removed these attacks were alleviated. It was recently reported in the literature that a person with cholelithiasis could have electrocardiographic tracings very similar to those found in thrombosis. Upon the removal of the gallbladder these electrocardiographic tracings would return to normal and the anginal pains would disappear.

I would like to leave this thought with you: if you do not possess an electrocardiographic machine you can be a very good doctor and also a good cardiologist. The prerequisites of being a good physician are still a thorough understanding of pathology and physiology. The electrocardiographic machine is only of secondary importance. If we pay more attention to what is going on in the psyche and in the gastro-intestinal tract we can often alleviate many of these irregularities of the heart which Doctor Salley has so thoroughly described.

*Dr. P. L. Dodge, Miami:*

I just want to say that I do psychiatry and I see many patients come in complaining of heart-consciousness. That is what I call it, because many of them are depressed and agitated and many mentally upset. They come in counting their own pulse, and sometimes it is almost impossible to get their hand down from over their heart. In fact they sleep with their hand over their chest because of fear that their heart will stop before they get to sleep. After they get to sleep, they get along fairly well.

The heart, of course, is one of the things

that lend to the consciousness of the patient more than anything else. We know when our heart is beating, we know when it flutters, we know when there is irregularity, and patients who are well suffer when they think there is anything the matter with the rhythm of the heart. I think every one of you must realize how important the mind is in relation to the rhythm of the heart. We can go to a moving picture and the heart beat will be perfectly smooth, but after we see a very exciting picture, without even moving out of our seat, our heart will begin to pound and go very fast. If we get into an accident or anything like that, the mind or psychic effect has a tremendous lot to do with the rhythm of the heart and the rapidity of it.

We must consider always the effect of the psychology of the individual over the rapidity and irregularity with which the heart beats. Personally, when I have these patients come in, I investigate from my own angle very carefully to determine if they have any heart pathology. And if I cannot determine that I refer them to a man who I feel is competent to determine that. But I do think that these mental cases that I see have a tremendous lot of difficulty because of the psychic effect on the heart beat.

*Dr. T. Z. Cason, Jacksonville:*

A few years ago Dr. Paul White of Boston presented a paper in which he gave the results of having followed for ten years two hundred patients, one hundred with extrasystoles and one hundred without premature beats. He separated these into two groups, auricular and ventricular. He found that the patients who had premature beats outlived the patients who did not. He also found, contrary to previously published statements, that those patients having ventricular extrasystoles outlived those with auricular extrasystoles.

I mention this, not because doctors are more susceptible than anyone else, but so that you may go home and continue to have your extrasystoles without the slightest fear whatever. Please do not misinterpret that statement; I am in no way depreciating the fact that they may be of consequence, for if there are many of them and the heart is already damaged, they may be of considerable significance.

I thoroughly enjoyed the paper by Doctor Salley.

*Dr. S. Marion Salley (Concluding):*

I am glad that the subject of premature beats was covered more fully by the discussants of this paper. This seemingly simple disturbance of cardiac rhythm can be at times most difficult to treat. It should be unnecessary to say that an electrocardiogram should be obtained whenever possible in these cases. However, it cannot be over-emphasized that many of these cases can be successfully diagnosed, if need be, without the electrocardiograph.

I wish to thank Doctors Torbett, Limbaugh, Kugel, Dodge and Cason for their discussion of this paper.

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### ADOLESCENT TURMOIL AGITATED DEPRESSION WITH PANIC REACTION

JESS V. COHN, M. D.,  
Hollywood

In 1932, O. Diethelm<sup>1</sup> very nicely spoke of panic as being "not merely a high degree of fear, but a fear based on prolonged tension, with a sudden climax which is characterized by fear, extreme insecurity, suspiciousness, and a tendency to projection and disorganization. The projections are delusions of persecutions and hallucinations; the disorganization may lead to a schizophrenic picture." In 1934, the same investigator<sup>2</sup> made a rather extensive survey of the literature on panic-states and offered his own observations.

It is quite generally accepted that panic, like fear, anxiety, and others, is one of the impure affective states, in contradistinction to the so-called pure emotions, elation and depression; and, of the group, it is the most distressing and the most treacherous. As a whole, the responsible factors are, of course, a succession of life-conditionings of the maladaptation sort, and comprising, also as a whole, the conscientious, rigid type of personality. From the analytical perspective, it is essentially an extreme frustration of the id, or unconscious drives, in the countenance of the super-ego, or the inhibitive factors of the conscience. This frustration was believed to be referable to the

sex experiences only and to most analysts is still entirely sexual, in the most complete analysis of the psychodynamics involved.

It is certainly easy to understand why turmoil of varying degree of intensity should occur precipitously at adolescence. As White<sup>3</sup> pointed out recently, adolescence is a period of special stress because instinctive tendencies assert themselves strongly and at a time when the adolescent is expected to conform to social conventions. Given, at such a time, a lack of sufficient security and love, which are so fundamental to the home life of the growing youth of prepuberty age, substitutions occur that are most important in the setting of the personality. In studying "nervous breakdowns" of adolescents by the questionnaire method among college students, Gardner<sup>4</sup> revealed the average age as 16.1 years, which is significantly adolescent and following directly upon puberty. He disclosed, following his study, a multitude of etiologic psychobiologic factors responsible directly or indirectly for the precipitation of a neurosis or psychosis; and the personality-types described were essentially the over-conscientious, the strongly inhibited, and the emotional-hungered.

One of the two principal reasons for presenting the following case history is that the genesis and progression, the sequential activity of psychic factors involved, in short, all the manifestations of a psychosis in this young man formed a compendium of human psychopathology as well as a dynamic presentation of the psychology that governs normal human behavior. The other reason is that because of the unusual exposition of unconscious play, the patient is an excellent subject for a research type of investigation, particularly as it applies to therapy.

#### CASE REPORT

The patient,<sup>5</sup> a white male of twenty, slender, and intelligent-looking, was admitted to the hospital on March 17, 1935, with a left black eye and left subconjunctive hemorrhage, an expression of bewilderment, and a remarkably intense desire to die. Well developed and well nourished, without any evidence of physical abnormality, he seemed intact structurally and functionally; and while he expressed a profound suicidal tendency, at the same time he expressed a fear of death. "I want to die. I'm afraid I'm going to die." He had suddenly quit his job as clerk with an insurance company in a large midwestern town the week prior to his admission, giving them neither reason nor notice, but telling us at the hospital that he felt he was losing his mind, and had better get away. He felt that if he did "break," he would be hard to control.

The first visitor interviewed was the patient's aunt, who, while she was somewhat reserved, was, nevertheless, more truly responsive and informative than the

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Read before the Sixty-fifth Annual Meeting of the Florida Medical Association, held at Miami, May 9, 10, and 11, 1938.



mother, who, it was felt, was still withholding relevant information because of her remarkably narrow conceptions of morality and immorality, right and wrong, etc. The aunt, however, gave the story that the patient had been acting peculiarly since the preceding Christmas, three and a half months before, when he began to prefer the solitude of his home to his otherwise outgoing practices, and the enjoyment of his own "dream-world," as he had said. He stared off into space constantly, talked queerly about wrong and right, God and the devil, and evil and had in connection with coming into the world. When asked about his speech content by his family, his response was most often something like, "Wouldn't you like to know?" His usual tidiness and consideration of external appearance were replaced by slovenliness, and a general unkempt condition. This change was progressive up to the time of admission. Two nights prior to admission, the patient insisted on walking about aimlessly in a rainstorm, much to the displeasure of his folks at home, and in spite of their exhortations to the contrary. He returned at noon of the next day, about fourteen hours later, with the above-mentioned signs of ocular damage, and with an obstinacy that was rebellious. He refused not only to account for his behavior, but to talk about anything at all. The family physician, who saw him that day, referred him to the hospital.

The history obtained from the boy's mother was essentially a corroboration of the aunt's. She added that he had always been shy and reserved; and volunteered later that while he had wanted to study at a university following his high school education, she successfully opposed this ambition, with resulting accentuation of his shyness. She had been separated from her husband for four years. The patient had been living in the midwest but away from his father, who lived in the same city. The boy would come home on weekends to visit his mother. Quite fond of both, he was, of course, considerably disturbed by their continued separation. The mother was extremely particular about the home and about the behaviour of her three sons, especially in matters of dignity, comparative social values and religion. Her first meeting with the patient in the hospital was characterized by great fussiness over him, crying, frequent kissing, and much "baby talk." She insisted, upon leaving, that she would cure him with prayer and Christian Science.

The landlord where the patient was staying told the boy's aunt that he had been acting peculiarly for about three weeks. On Saturday night the patient would go out with two rough-looking men from Chicago. On several occasions the landlord noted the patient's undergarments were torn and very mussed, with a peculiar odor. His return home after going out with these "bums" would be characterized by apparent depression and moroseness. Additional information gathered from the relatives indicated that the boy never seemed to have enough money in spite of his salary of sixteen dollars a week. The probability that the boy was fleeced by the men was suggested by the aunt.

#### SOMATIC HISTORY

The patient's appetite had been impaired for three weeks prior to admission, and he had slept poorly during the past few months. A physician was not called because it was felt by the parents that the boy's trouble was due to infernal spirits of some sort working within him, and that belief in the Divine Faith and Holy Science was his salvation. He had never had any serious illnesses. The only result of an automobile accident two years previously was a small laceration on his head, with rapid recovery. The history of individual systems was negative. He had lost some weight during the past month, how much was not known. There was no history of such occurrences as severe influenza, delirium, headaches, diplopia, dizziness, ataxia, scotomata, convulsions, nausea, vomiting, or any other organically produced neurologic signs.

#### FAMILY AND PERSONAL HISTORY

Both parents were living and well, but had been separated for four years. The patient was the youngest of three boys, the other two being in good health and, as far as could be determined from the family, showed no abnormal mental trends. There was no history of any malignant familial diseases, no epilepsies, psychoses, etc.

The patient was a normal newborn, who passed through a normal infancy, walking at sixteen months, and talking at two years. He never sucked his thumb. No history of enuresis was obtainable. Having begun his schooling at the age of five, he completed the fourth year of his high school training at the head of his class, even skipping one grade. He was never interested in extra-curricular activities, clubs or organizations. He went out for track once, but failed to make the team. There was no history of stealing, lying or legal difficulties. His work record was good, as he had been employed by this single life insurance company since graduation from high school four years before; he was always a steady and industrious worker. He never drank, smoked, or took drugs of any kind. He had had no recent medication.

The patient had always been of the shut-in type, with few friends though he was well acquainted. He seldom sought the company of girls because, he said, of his "bad breath." He added that men shunned him for the same reason. He had been shy and seclusive. His personality was at first rigid, but later gave evidence of a moderate degree of plasticity that eventually, during the course of his hospitalization, permitted of some superficial acceptance of other points of view as administered by his doctors. He had very powerful feelings of guilt for the "crimes" he had committed.

There was no history of heterosexual experience. One of the other patients in the ward told us that on the day of admission the patient told him that he had been masturbating two or three times a day for the previous month, that his nocturnal erections and emissions were very frequent, and that these occurrences were giving him considerable mental torment. He had masturbated much since the age of sixteen. At first he denied homosexual experiences, later admitting them to some of us.

His hobby was reading, especially the classics, and more especially the works of Tennyson. His religion, or rather that of his parents, was Christian Science. He had always been interested in religion and church, attending quite regularly during the past four years. His aunt had thought often that he was abnormally interested in the church. The intern noted on one occasion: "The environment of the home is super-religious, and steeped in the doctrines of Christian Science."

#### MENTAL STATUS

On admission to the hospital, the patient expressed an intense desire to die, with the ambivalent plea that he be saved. He also not only asked for castration but attempted it himself by tearing at his genitalia. Besides this, when his wish for both focal and general mutilation were not accepted by the people to whom he appealed, he attempted it himself by biting his left arm in several places sufficiently to produce a lymphangitis with axillary adenitis. He had been observed on several occasions to try to rid himself of his tongue at the root. Biting his tongue at the midpart was not sufficient. Holding his breath was, of course, also ineffective.

His perturbation, confusion, and turmoil expressed themselves at every attempt on the part of the examiners to get under the surface—these in spite of an excellent rapport. His conduct was suggestive of frozen panic and a schizophrenic psychosis was superficially evident. His remarks to the effect that Christian Science and the effect of mind over body, and mind over mind, are supreme, we interpreted as merely a rever-



beration of his constant domestic circumstances. The attending nurses reported that his delusions often hinged on religion; he thought at times he was the devil; at other times he was God; he thought his death would bring salvation to others; also that he would be burned for his sins.

#### COURSE IN HOSPITAL

His course in the hospital was tumultuous, with frequent attempts at focal and general suicide; need for severe restraint; superficial, momentary insight, that served only to indicate the malignant trends of which we were justly afraid; and the apparent fixation of his bewilderment. He made sincere, conscious efforts at understanding, but they were certainly not stable ones. Sedatives were necessary nightly to insure sleep. Reassurances were constantly necessary, with resulting passive insight, which was, of course, false. Just a week after admission, he made another attempt at auto-castration while taking a tub bath.

His temperature varied intermittently between 98 and 101.4 degrees rectally determined. Three times his pulse was found accelerated to above 120, out of all proportion to temperature. The respiratory rate remained constant at about 20. The white blood cell count on admission was 13,100; two weeks later it was 8,000. Five urine samples proved negative. Blood and spinal fluid serology were negative, except for a trace of globulin in the latter. The only medication the patient received was barbitol, grains  $2\frac{1}{2}$ , four times daily.

A diagnosis of adolescent turmoil was made, even in face of the orthodox manifestations of a schizoid change from the normal—this following a consideration of the type of onset, the absence of a true schizoid personality to start with, the stormy course, the extrovertive activity even during this psychotic episode, and the strongly suggestive favorable prognosis. The latter was brought out when the patient, who had strong ideas toward suicide and self-mutilation, at the same time wanted to hold my hand during our interview. He addressed me as "father." He poured forth new material at each seance, as it were, with resulting comfort to him.

His fleeting grimaces, strongly psychotic behaviour, and bewilderment disappeared when he was being given a re-education in matters of sex and social criticism. He asked for more of the therapy that was being given him, but it was felt that the intensity of the treatment, the abruptness of his return to a realization of reality as it exists, prevented a too prolonged continuation of this type of treatment. It was felt that frequent attacks on the part of a male psychiatrist who had effected a satisfactory transference was the preferred method—in an institution such as a psychiatric hospital, of course.

This patient was not followed into convalescence because shortly after improvement made itself manifest, his relatives moved him to a remote little village somewhere in the middle west, where he might identify himself with Christian Science and receive what, in the opinion of his mother, would be his only salvation.

His treatment while in the hospital consisted essentially of protection against suicide, sedation hydrotherapeutically and with split doses of barbitol, and psychotherapy; attempts to establish security by assurances, encouragement, commendation, and some occupational therapy.

I believe that the constant, dynamic play between the major opposing forces in mental mechanisms has been very dramatically exposed in this single clinical instance, particularly because this case presents in exaggerated pantomime what we choose to accept as the psychodynamics that govern normal human behavior. It happens that this was a case of adolescent turmoil with very definite evidences

of agitated depression<sup>6</sup> in which some of the responsible, etiologic factors were a gradually increasing, general sex upheaval (embracing homosexual, heterosexual, and auto-erotic tendencies); frustrated ambitions; incomplete social education; a faulty, ignorant, domestic environment; and the reverberations of guilt-feelings and inadequate sublimations.

Since the time of the original presentation of this case report, I have had the opportunity of seeing the end-result of a patient suffering from a remarkable imbalance among the systems endocrine, sympathetic nervous, and psychomotor. This case history very particularly (and briefly) demonstrates at least a suggestive relationship between the thyroid gland on the one hand and behavior on the other hand, with the ravages that can result to the somatic frame as the structure that houses them both.

#### CASE REPORTS

The patient, a male of 18 years, was first seen in neuropsychiatric consultation on March 29, 1937. At that time he displayed the classical syndrome of well-advanced, deteriorating schizophrenia, with apathy, ambivalence, autistic thinking, auditory and visual hallucinations, delusions of persecution, etc. The physical examination revealed nothing "positive"; that is, there was nothing demonstrable to focus attention on the patient's physique. All laboratory examinations were negative. I must stress at this time, however, that he was a lean, handsome youth, of 130 pounds in weight, a full head of hair that was of normal texture, normal elasticity of the skin, etc. The diagnosis made was not dementia praecox or the acute psychotic episodes that occur with toxicities of exogeny or endogeny, but adolescent turmoil, of psychic origin, and with a favorable prognosis.

The lad was not hospitalized; and under the guidance of his understanding parents, and psychotherapeutic efforts at my office, he gradually but definitely improved until, in August, four months after the onset of his illness, he was rapidly gaining insight into his abnormality, with resultant psychiatric recovery.

About two or three months following this, he began to gain weight, his hair became brittle, and severe alopecia areata occurred, myxedematous changes appeared, and ambition became diminished all collectively interpreted as the clinical evidences of thyroid deficiency. Whether the endocrine disturbance was latent at the onset of the illness and was hiddenly responsible for the precipitation and course of the disease-process, or whether the thyroid deficiency resulted from the dynamic actions of the psychogenic factors involved (such as the demonstrable occurrence of peptic ulcer from mental conflicts), is at this time only conjectural. However that may be, the fact remains that physical improvement manifested itself shortly after the institution of thyroid medication.

The problem, then, of what we accept today as psychogenic disturbances, particularly the adolescent turmoils, panics, and depressions, may be solved by a comprehensive insight on the part of the investigators into the correlated action of the endocrines, the sympathetic

nervous system, and the psychomotor behaviorisms.

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#### 207 Central Arcade

### PROSTATIC CALCULI

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The occurrence of two cases of prostatic stones in my practice during the last three months prompts the present discussion of the subject. Both of these cases occurred in men between the ages of forty and fifty years, and in neither case was there any evidence of prostatic enlargement.

#### CASE REPORTS

CASE I. The only symptoms complained of in the first case, (J.F.H.), were low sacral backache and occasional urinary burning. He had never passed either gravel, stones or blood in his urine. The general physical examination was irrelevant. On rectal examination the prostate was found to be of normal size, but abnormally boggy. A hard, sharply defined area was found in the left lobe, which felt very much like a stone. The prostatic secretion contained two-plus pus. Cystoscopic examination and routine investigation of the upper urinary tract was negative. X-ray of the pelvis showed a triangular prostatic stone  $1\frac{1}{2}$  cm. by 2 cm. in diameter.

Treatment of this case consisted of biweekly prostatic massage, together with endoscopic applications of silver nitrate. Eight Elliott treatments were given after the first week. The patient was asymptomatic after six weeks, but continued to show 18 to 20 pus cells per high pressure field in the prostatic secretion.

CASE II. The second case, (B.C.), was seen because of a pyuria found during an insurance examination. The patient had no symptoms referable to the genito-urinary tract and his past history was of no urological significance. Cystoscopic investigation ruled out the kidneys as the source of the infection. Rectal examination revealed a prostate normal in size and shape, but definite crepitation was felt in both lobes. This finding became more marked after he had several massages. The prostatic secretion contained three-plus pus. An X-ray was made of the pelvis which showed multiple seed stones in both lobes of the prostate.

This patient is showing definite improvement with biweekly prostatic massage together with endoscopic treatments and autogenous vaccine therapy.

Stones found in the prostate fall under one of two main groups: the endogenous, which are formed in the prostatic substance, and

which at least at their inception do not come in contact with the urinary salts; and secondly, the exogenous, which are formed higher up in the urinary tract and are merely arrested in the prostatic urethra in passing, and there tend to grow in size. There are three types of these endogenous prostatic stones: multiple small round (seed) stones, large round intraprostatic stones which are faceted when multiple, and massive calcification of the prostate which is attributed to a preexisting tuberculous process. Various classifications of prostatic stones have been made by various writers to indicate their possible origin, as, stones associated with prostatitis, hypertrophy of the prostate and tuberculosis.

The exogenous stones are not true prostatic stones, since their origin is elsewhere, and are composed of urinary salts. Urinary calculi lodged in the prostatic urethra or in a communicating pouch or pocket should not be included. This type of stone can be differentiated from the true prostatic stone which has eroded through the prostate and acquired a secondary coating of urinary salts by the chemical examination of their nuclei. The true prostatic stone has an albuminoid nucleus, while the exogenous stone has a nucleus composed of uric acid, urates or oxalates.

#### ETIOLOGY

The origin of true prostatic stones is open to debate. The most logical view as to their origin is that they are formed by the deposits of calcareous material on the corpus amylacea which are frequently met in the secretions of normal glands. Corpora amylacea are round to oval bodies composed of a nitrogenous material of an albuminoid nature and usually contain some lecithin. They are found in the alveoli of the prostatic gland, and are more numerous as age advances. They have a marked tendency to calcify and in men past middle age they are almost invariably impregnated with lime salts.

Joly believes that the deposition of calcium is brought about by a difference in surface tension between these minute bodies and the surrounding prostatic fluid. Thompson assumed that the corpora amylacea act as irritating agents, thus causing a deposition of calcium salts similar to that which occurs in



the bladder in the presence of a foreign body.

Prostatic stones usually occur in adults between the ages of forty and sixty. Joly found two-thirds of his cases to occur between fifty and seventy. In a series of seventy-seven cases reviewed by Kretschmer, over seventy per cent of the cases occurred between the ages of forty and seventy. However, in a series of cases reported by Thomas and Roberts, they found four boys ten years of age with prostatic stones.

There are several pathological conditions which are found associated with prostatic stones. There is always more or less of a chronic prostatitis present and urethral strictures are relatively frequent. The most commonly associated condition, however, is that of benign prostatic hypertrophy. The finding of multiple seed calculi between the inner hyperplastic and the outer compressed prostatic layer or surgical capsule is common at the time of prostatectomy, particularly by perineum. Carcinoma of the prostate seems to be a rare accompanying lesion; however, Kretschmer found five in his series of seventy-seven cases. Abscess because of stone is very rare.

#### SYMPTOMS

There is no symptom complex characteristic of prostatic stones, because of the other lesions of the urinary tract which are associated. However, urinary symptoms predominate, such as frequency, urgency, burning and dysuria. Sexual symptoms are present sometimes, but rectal symptoms only rarely. Localized and referred pain is common. Pain in the perineum arises from sitting on hard surfaces. In some cases prostatic stones have been passed in the urine. It must be borne in mind that in most cases these symptoms are not due primarily to the prostatic stones, for the latter are often present with no symptoms whatsoever and are found only on the routine examination of the urinary organs.

#### DIAGNOSIS

The x-ray is the final judge in making the diagnosis of prostatic stones. However, in interpreting the x-ray plates in these cases one must bear in mind the possibility of phleboliths in the periprostatic plexus of veins. Sometimes prostatic stones are first suspected from the grating which they impart to an in-

strument passed into the urethra. Occasionally one can see the stones protruding from the prostatic ducts at the time of cystostomy. I have seen one case in which the stone caused a distinct bulge in the urethra and the overlying mucous membrane showed a bluish discoloration. When this was fulgurated the electrode encountered the hard stone beneath. Stones are often suspected from the rectal examination, because of the irregular circumscribed hardness which they cause. If crepitation can be elicited in the prostate, it is diagnostic of stone. Prostatic stone can simulate carcinoma closely on rectal examination. Very hard isolated nodules of carcinoma may feel like stone, and vice versa. The entire prostate may feel stony hard because of multiple calculi. The sclerosis of chronic prostatitis, the induration of carcinoma, and the nodulation of tuberculosis must all be differentiated from prostatic stones. The differential diagnosis is easily made with the x-ray, or occasionally by eliciting crepitation on rectal pressure.

#### TREATMENT

The treatment of prostatic calculi will depend on the severity of the symptoms and on the other urinary lesions that are associated. In silent cases no direct treatment is required. When prostatic hypertrophy accompanies the stones, as it commonly does, the treatment of this condition is of primary importance, and the stones secondary. The calculi are easily removed, either suprapubically or perineally, at the time the prostatic adenoma is removed. Many times the stones, especially if they are small ones, can be removed during a prostatic resection. The presence of stones is in no way a contraindication to resection. A surprising number of the small seed stones are found clinging to the gauze sponge when one sponges out the cavity resulting from the suprapubic enucleation of the prostate. The larger prostatic stones are often found lying in pouches in the prostatic tissue, and in such cases there is a remarkable degree of destruction of the prostatic tissue.

In those cases associated with a urethral stricture, the proper dilatation of the stricture will often cause the symptoms to disappear, and the prostatic stones are not disturbed.

It is almost impossible to cure a chronic



prostatitis when stones are associated, as they continue to act as an irritating foreign body regardless of treatment. Every case of chronic prostatitis that fails to respond to the usual methods of treatment should be x-rayed to determine whether stones are present.

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#### ACUTE EMPYEMA THORACECTOMY

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Empyema of the chest implies a collection of purulent fluid in the pleural cavity. It is usually a complication of an infection in the lung, a lobar or bronchopneumonia, influenza, measles, scarlet fever, lung abscess, or a gun shot wound may be antecedent.

Empyema is relatively easy of diagnosis if the physician has it in mind. In every case of pneumonia empyema should be suspected when symptoms develop after the crisis or after the time when the crisis is expected. On inspection the affected side is fuller and the intercostal spaces widened; percussion yields a flat note extending from the base upwards to an extent depending upon the amount of exudate. The highest point is usually posteriorly. To auscultation the sounds over the fluid area are absent or distant.

The aspirating needle furnishes a certain means of diagnosis if the physical signs point to fluid in the chest. The point for diagnostic

aspiration is the sixth or seventh interspace in posterior axillary line. This minor operation should be performed carefully and with aseptic precautions, one per cent novocaine being used to raise a wheal and with a 5 cc. syringe the anesthetic injected into the muscles and beneath the rib.

In order to undertake the successful treatment of a case of empyema it is essential to evaluate the stage of the effusion, the general pathology of the chest, and the condition of the patient. About ten days after pneumonia crisis the usual empyema will have become loculated and the lung fixed. The pus is creamy, of sweetish odor, may be sterile. If the patient is sick,—that is, septic—or is a child, a simple underrib puncture and drainage is sufficient for the time. Rib resection can be done later.

The observations and studies made by the Empyema Commission established by the Surgeon General of the Army in 1918 developed a number of fundamental basic principles which still form our present-day therapy. In addition, however, a review of the literature indicates that with the hope of lowering the mortality of empyema many and varied details of treatment have been advocated by various authors. The one principle which is fundamental and now universally accepted is the avoidance of the creation of a pneumothorax in the formative stage of empyema. Before this was emphasized open drainage in the early stage of the disease produced a high mortality.

When the empyema is a true abscess, either closed or open methods of drainage may be advocated. The latter procedure is founded on the experience of many surgeons and their opinion produces the best results. When creamy pus is found either the closed method or rib resection may be used. For the closed method tidal drainage as modified by Overholt of Boston provides a simple and effective method of draining the empyema cavity especially in young children. In brief, the method consists of inserting a trocar and cannula intercostally and slipping in a No. 32 mushroom catheter, then utilizing the ordinary movements of the chest during respiration to provide tidal drainage.

Overholt pointed out that the older methods of closed drainage failed because excessive

suction was applied to the chest by placing the drainage bottle too far below the level in the chest. He converted the old system into one of tidal drainage by regulating the levels of the fluid inside and outside the chest. The drainage bottle is placed on a table so that the level of fluid on the table is only two to four inches below that in the chest. In this way the siphonage pressure is less than the intrapleural pressure and a slight to and fro movement is set up.

In rib resection the novocaine infiltration must be thorough. A wheal about four inches in length should be raised by successive injections of novocaine 1 per cent and with a 3-inch needle the subcutaneous tissues should be well saturated for a distance of several inches. The incision which is usually the eighth rib in the posterior axillary line is made down to the muscles and these well infiltrated before cutting. When the rib is reached the needle should be introduced above, below, and behind the bone at either end of the incision, care being taken not to introduce novocaine solution into the vessels. An incision is then made on the bone above and below to separate the intercostal muscles and a periosteal separator gently introduced, separating the periosteum and intercostal tissues from the posterior aspect of the rib. The rib is then cut and a portion  $1\frac{1}{2}$  inches removed. After the opening is prepared the pleura is infiltrated with novocaine and a pair of pointed hemostats introduced through the pleura and gently spread. Almost at the same moment a fairly large drainage tube is introduced, a clamp being used on the outer end to prevent pus from spilling. The muscles are rapidly sutured to either side with a few chromic catgut sutures, and the skin closed with silkworm gut. Most authors say that the closed method of drainage should be practiced and the tube connected with a bottle below the chest fluid level.

In the cases I have treated I did the classical rib resection using a fairly large tube, about six inches long, only irrigating with boric acid solution when there was any blocking of drainage by fibrin. Every few days the tube was withdrawn and an inch clipped off.

The following are cases I have treated since 1934:

CASE 1. A. M. T., a four-year old white girl, had lobar pneumonia of the left base. The pneumonia lasted nine days and was followed on the twelfth day by development of empyema. A thoracentesis was done which showed creamy yellow pus. On the nineteenth day a rib resection was done, using the seventh rib, left mid-axillary line. Six weeks later the tube was removed and the patient had a normal recovery.

CASE 2. E. R. P., a five-year old white girl, developed pneumonia of the right base which was followed by empyema on the eighteenth day. Thoracentesis was done by Doctor Baltzell and several cc. of pus, not very thick, were withdrawn. It was decided to defer rib resection. In a few days, Doctor Baltzell being out of town, I was called. On thoracentesis, creamy pus was found. Rib resection was then done. In four weeks the tube was entirely removed and she had a normal recovery.

CASE 3. H. E. H., an eight-year old white girl, had a right lobar pneumonia which lasted nine days and on the fourteenth day developed empyema. I was called on the seventeenth day when creamy pus was found on thoracentesis. Rib resection was performed. The patient made a normal recovery in six weeks.

CASE 4. H. M. E., an eleven-year old girl, had been sick for over two months when she came under my observation. Her illness began with pneumonia of the right base. She had been treated out of the state until Doctor Ryals of Dellwood saw her and made a diagnosis of empyema. Thoracentesis showed a creamy yellow pus and a rib resection was done. It was three and one-half months before we were able to remove the tube entirely and in this case we irrigated with boric acid solution regularly. I had occasion to examine this girl a few weeks ago. Her lungs are in perfect condition and there is no deformity of the thorax.

CASE 5. C. H., a boy aged 12, had a left lobar pneumonia and on the fifteenth day developed empyema. Rib resection was performed and in six weeks the tube was removed. He made an uneventful recovery.

CASE 6. E. H., a brother of C. H. (Case 5), developed lobar pneumonia of the right base a few days after C. H. On the seventeenth day rib resection was performed and he had a normal recovery in nine weeks.

The father of these boys who did much of the nursing developed lobar pneumonia and had a stormy course but did not develop empyema.

CASE 7. J. W. M., a white man aged 24, was brought into the hospital suffering with pneumonia of the right base. On the twentieth day a thoracentesis was done and creamy yellow pus found. A rib resection was performed and on the tenth day he was sitting up. I let him return to his home near Blountstown. In seven weeks the tube was removed and he had no chest deformity following.

CASE 8. A colored male, aged 5, developed left lobar pneumonia on May 1, 1938, which lasted eleven days. On the fourteenth day I noted a flatness on percussion and absent breath sounds, so three or four days later I aspirated thick yellow pus. Rib resection was immediately performed and on July 1, I removed the tube. He is still improving.

In all except one of these cases, operation was done at home. No regular irrigations were given and only occasionally was boric acid solution used to soften the fibrin and start drainage. All tubes were removed in four to eight weeks except one in a case of empyema of long standing. None of these patients had chest deformities and there were no deaths in the series.

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(Address all communications to Box 1018, Jacksonville)



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## PHYSICIANS AND SURGEONS (M.D.) NEW LISTING, TELEPHONE DIRECTORY

In the telephone directories for Florida of the Southern Bell Telephone and Telegraph Company, the classified section shows medical doctors with the suffix "M. D." In the alphabetical list the suffix "Dr. Phys." is shown after each medical doctor's name. Other practitioners of the healing art in Florida are listed under different symbols. The public now when referring to telephone directories, will be able to select its doctors more intelligently.

For many years representatives of the medical profession have urged the Telephone Company to show these listings in such manner as to make it possible for an individual to call a doctor and know before the call is made, under what branch of the healing art the doctor is licensed. The officials of the Telephone Company contacted did not seem to think there was sufficient authority for the different listings requested. The change in ruling by the Telephone Company came about

after the passage of a law at the last session of the legislature, requiring practitioners of every kind or branch of medical and/or material healing arts to place and keep at the entrances of their offices or usual places of business words or proper abbreviations denoting the particular kind or branch of the medical and/or material healing art they are licensed to practice. This new law has apparently been the means of providing the Telephone Company with proper authority to show "M. D." for doctors of medicine who are licensed to practice in Florida.

It has been stated that this special listing is not made for other states, where special laws have not been passed.

A number of visits were made back and forth between the home office of the Florida Medical Association and the office of the Telephone Company in Jacksonville. It is a pleasure to report that the officials of the Telephone Company cooperated very generously. In the classified listing of M. D.'s for Jacksonville, one chiropractor and three naturopaths were listed under the caption, "M. D." An official of the Telephone Company was immediately contacted and an official letter received on January 24, advising that these four names would be deleted in the future from the M. D. listing and placed in their proper classifications.

Telephone directories for each city in Florida should be carefully checked to see that there are no names shown under "M. D." of other than medical doctors. Officers of the county medical societies are urged to see that this verification is worked out without delay. If the checking is done locally, irregular listings may be reported or the entire list may be sent to your home office, Box 1018, Jacksonville, and the names will be checked for you and any irregularities discovered will be reported immediately to the Southern Bell Telephone and Telegraph Company for correction, in its next directory. Better results will undoubtedly be secured by using your home office as a clearing house and less confusion with the officers of the Telephone Company will be experienced.

## PRE-CONVENTION MEETING

The Pre-Convention meeting of the Association was held in Jacksonville, January 29 at the Roosevelt Hotel. Beginning at 9 a. m., the forenoon was devoted to various committee meetings. Twelve separate rooms were reserved for these committee groups. Many of the doctors arrived Saturday night and remained over the following day.

After the busy morning, a luncheon was served at 1 p. m. in the ballroom, followed by the General Session, with Dr. W. Henry Spiers, president, presiding. Under the heading of committee reports, Dr. Walter C. Jones, chairman of the Committee on Scientific Work, made a very brief report, stating that seventeen papers had been selected for the scientific sessions at the annual convention in Daytona Beach next May. Dr. Gilbert S. Osincup, chairman of the Executive Committee, reported that the schedule of sessions for the annual convention had been adopted by his committee and that Hillsborough County Medical Society's invitation for the 1940 annual convention would be recommended to the House of Delegates.

Brief verbal reports were made by the following: Dr. Henry E. Palmer, General Advisory Board of Past Presidents; Dr. John N. Moore, Committee on Medical Education and Hospitals; Dr. J. Ralston Wells, Public Relations Committee; Dr. G. W. Potter, Necrology Committee; Dr. Turner Z. Cason, Committee on Medical Postgraduate Course; Dr. J. C. Vinson, Committee on Medical Economics; Dr. Edwin C. Swift, Committee on Inter-Relationship; Dr. J. C. McSween, Committee on Tuberculosis and Public Health; Dr. H. D. Van Schaick, Committee on State Controlled Medical Institutions; Dr. Ferdinand Richards, Maternal Welfare Committee; Dr. Luther W. Holloway, Child Health Committee; Dr. Gordon H. Ira, Advisory Committee to Woman's Auxiliary; Dr. E. T. Sellers, Committee on Venereal Disease Control. President Spiers reported for Dr. Thomas O. Otto on the Legislation and Public Policy Committee.

At 3 p. m. the gavel was turned over to Dr. Harrison A. Walker, chairman of the Council, who reported that the Council had adopted a schedule for annual medical district meetings

during 1939; and that one new county medical society had been organized in councilor district number 2, this new society to be known as the Franklin-Gulf County Medical Society. Owing to the lateness of the hour, with the consent of the councilors present, Doctor Walker ruled that the individual councilors' reports would be read by title only and published in the Florida Medical Journal.

The meeting was turned over then to the Committee on Legislation and Public Policy, with Dr. W. C. McConnell presiding, assisted by Dr. B. M. Rhodes and Doctor Spiers. The officers and members interested in the coming session of the legislature were invited to attend this meeting. A very full report, in Executive Session, was made and discussed and suggestions received from those present for the guidance of the Committee. The membership of the Association will be advised concerning the plans, as soon as the Committee, with the assistance of Doctor Spiers, has had time to definitely formulate an outline. The members who registered at the luncheon meeting are as follows:

*Century*: J. I. Turberville, John S. Turberville. *Chattahoochee*: Ralph E. Stevens. *Cocoa*: Walter C. Page. *Daytona Beach*: J. Ralston Wells. *DeLand*: C. E. Tribble. *Ft. Pierce*: A. M. Sample.

*Gainesville*: Edwin H. Andrews, John E. Maines, Jr., W. C. Thomas, G. C. Tillman. *Jacksonville*: T. Z. Cason, Luther W. Holloway, Gordon H. Ira, Edward Jelks, Louie M. Limbaugh, J. G. Lyerly, A. B. McCreary, Robert B. McIver, W. A. McPhaul, S. R. Norris, Ferdinand Richards, Shaler Richardson, E. T. Sellers, W. McL. Shaw, Edwin C. Swift, H. Marshall Taylor, H. D. Van Schaick, F. J. Waas.

*Lake City*: R. B. Harkness. *McIntosh*: J. L. Strange. *Miami*: Walter C. Jones, Joseph S. Stewart. *Miami Beach*: Harrison A. Walker. *Ocala*: Henry C. Dozier, R. D. Ferguson, Albert H. Freeman, John N. Moore, Ralph E. Russell. *Orlando*: C. J. Collins, Hewitt Johnston, Meredith Mallory, Gilbert S. Osincup, W. Henry Spiers. *Pensacola*: J. C. McSween. *Plant City*: John W. Alsobrook.

*Quincy*: Julius C. Davis. *St. Augustine*: G. W. Potter. *St. Petersburg*: William M. Davis, W. C. McConnell, A. L. Mills. *Talla-*



*hassee:* J. Kent Johnston, F. Clifton Moor, Henry E. Palmer, B. M. Rhodes. *Tampa:* J. C. Vinson. *Vero Beach:* E. B. Hardee. *West Palm Beach:* W. W. George, Lloyd J. Netto.

### ADVANCES IN GRADUATE EDUCATION

The Medical Postgraduate Course Committee is contemplating some experiments to be given in Daytona Beach from June 19 through June 24, 1939. A course covering the entire week will be offered to those who wish advance instruction in the diagnosis and treatment of tuberculosis. A full-time instructor will give three lectures daily together with demonstrations. The course will be further supplemented by physicians from the State Tuberculosis Sanatorium and other men in the state specializing in diseases of the chest. The attendance will be limited; advance registration for the special course must be made through the Chairman of the Committee.

Details of the entire Short Course program will be found in the next issue of the JOURNAL.

### SPECIAL COMMITTEE ON NATIONAL HEALTH PROGRAM

On Sunday Jan. 15 the special committee or the House of Delegates of the American Medical Association conferred in Washington with the Interdepartmental Committee to Co-ordinate the Health and Welfare Activities of the United States Government, *The Journal of the American Medical Association* for Feb. 4 reports. Those present included Drs. Vest, Carey, Donaldson, Luce, Rankin, Sondern, West and Abell, with the addition of Dr. Woodward. The Interdepartmental Committee was represented by Chairman Josephine Roche, Mr. Altmeyer, Dr. Parran, Mr. Perrott and the members of the Technical Committee on Medical Care, Drs. Martha Elliott, J. W. Mountin and C. E. Waller and Messrs. I. S. Falk and G. H. J. Perrott. Opportunity was given for extended discussion of the various recommendations in the National Health Program. The committee representing the American Medical Association presented the point of view of the House of Delegates. It was apparent that the Technical Committee had not receded in its attitude in favor of compulsory sickness insurance.

On Monday, Jan. 16, the special committee of the House of Delegates, together with Miss Roche and Dr. Parran, were received by the President. Dr. Abell briefly stated the attitude of the American Medical Association and repeated the offer of the American Medical Association to aid in working out the problem. Obviously the conferences with the Interdepartmental Committee in nowise changed its attitude. Its report, as sent to Congress by the President, is in all particulars approximately the same as presented to the National Health Conference in July, 1938.

### REPORTS OF DISTRICT COUNCILORS\*

#### FIRST DISTRICT—

CAROL C. WEBB, M. D. . . . . *Pensacola*  
Bay, Escambia, Holmes, Okaloosa, Santa Rosa,  
Walton, Washington.

From my observations, Bay, County Medical Society is very active at the present time and entertained splendidly the Northwest District meeting last July.

I have approval from the Escambia County, Jackson County, Bay County, Leon-Gadsden-Liberty-Wakulla-Jefferson County and Walton-Okaloosa County Societies to set Friday, the 21st of July as the date for the next annual Northwest (A) District Medical Meeting at Marianna. I am also impressed with the fact that Walton-Okaloosa County and the Washington-Holmes County Societies are thoroughly cooperative with our association.

I have at this time appointments at which time I shall meet with these individual societies in my district in order to take to them any message from the annual pre-convention meeting.

Escambia County has been very active in the past year with many scientific programs. We have entertained the Gulf Coast Clinical Society, at which time a splendid scientific program by many able men of our profession was submitted through its two-day session.

At all times, the First District desires to completely cooperate with its parent organization and pledges to you its support in 1939.

#### SECOND DISTRICT—

N. A. BALTZELL, M. D. . . . . *Marianna*  
Calhoun, Franklin, Gadsden, Gulf, Jackson, Jefferson, Leon, Liberty, Wakulla.

It gives me distinct pleasure to report to you outstanding progress in organized medicine throughout the Second Medical District for the year 1938.

The Second District Medical Society comprising the counties of Leon, Gadsden, Liberty, Wakulla and Jefferson is a credit to any medical sub-division in the State; meetings are held alternately at Quincy, Chattahoochee and Tallahassee quarterly; their scientific programs are most interesting and instructive.

We are proud to report the organization of the Franklin-Gulf County Medical Society. This society, though newly organized, is making unusual progress for a young organization. The members are very enthusiastic and holding regular meetings.

The Jackson County Medical Society, the third integral unit of organized medicine in District No. 2, is progressing nicely. With the installation of new blood an added interest has been manifest and they are meeting regularly with good programs at each meeting.

\*Read by title before the Pre-Convention Meeting, Jacksonville, January 29, 1939.



While Calhoun County is the only county in the District not separately organized, a majority of its doctors have become regular members of the Jackson County Medical Society.

### THIRD DISTRICT—

R. B. HARKNESS, M.D. .... *Lake City*  
Baker, Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor.

The Third District embraces eight counties. During the past year interest in organized medicine within our district has been most gratifying. While a number of our counties do not have societies, most of the doctors in such counties affiliate with some adjoining county society, thus maintaining contact with the State Association.

The regional meetings held annually in the medical districts during the past two years, are a decided stimulus in favor of organized medicine and should be continued as a permanent policy of the State Association. The meeting for District B held at Gainesville was well attended by officers of the State Association, as well as by individual doctors in the district. After the business meeting an interesting and instructive scientific program was presented with J. L. Strange, councilor for District Four presiding.

For several years, the spectre of State Medicine has kept the medical profession disturbed. But we have looked upon this as a problem for the future. Today organized medicine in Florida is face to face with problems of the utmost portent. Recently in a conference between a group of the medical men in West Florida, and representatives of the Federal government, the matter of medical care for indigent farmers was considered. Inasmuch as the proposed solution offers the doctor some compensation for a class of patients heretofore attended by him as an act of charity, we must look with favor on the plan. It is proposed to leave both the patient and the doctor freedom of choice, and so must be considered as fair. But again, there is a factor of reduced fees for the doctor, that may involve far-reaching implications, this in the face of a very extensive program fostered by our national government, reaching into the relation between the doctor and his clientele which should be studied carefully. And to this end, your councilor would recommend that this whole question of cooperation between the medical profession in the State of Florida and the Federal government, be referred to a committee which will report to the Florida Medical Association at its next annual meeting.

### SEVENTH DISTRICT—

J. W. ALSOBROOK, M.D. .... *Plant City*  
Hillsborough, Manatee, Pinellas, Sarasota.

This early meeting has caught me short on visits to the component medical societies in my District, but the Secretaries have been very prompt in submitting reports requested by mail and telephone.

The District meeting was held at Bradenton under the auspices of the Manatee County Medical Society, was well attended and a good program presented. At the dinner hour we had a paper on Medical Economics, which was timely.

The Florida Midland Medical Society lost its secretary-treasurer, Dr. Butler Hall Sanchez by death, September 21, 1938, and following his death Doctor McConnell, the president, sent out a questionnaire asking what was the will of the membership. They voted more than 90 per cent to disband and unite with the Southwest District of the Florida Medical Association. Doctor McConnell is to be commended for this action, as the two societies were overlapping in membership and purpose. It is to be hoped that other sectional societies will do likewise.

The Manatee County Society hasn't been very active during the past year, but held monthly meetings, except in July and August, with two new members and one prospective member and a total membership of sixteen, with all dues paid for 1938. At the November meeting Constitution and By-Laws was adopted. At a joint

meeting with the Sarasota County Society in December, it was voted to meet together during 1939. This will cause more interest. New officers are: president, Samuel Hollingsworth; vice president, Blake M. Lancaster; secretary-treasurer, M. M. Harrison. No reports have been sent to the A. M. A. regarding the medical survey.

Sarasota County Medical Society held no meetings during the summer; membership dues were 100 per cent paid for 1938. No reports have been sent to the A. M. A. on free medical service. New officers elected: president, T. W. Taylor; secretary, Stanley T. Martin.

The Hillsborough County Medical Society was host to the International College of Surgeons' sectional meeting on February 28, 1938, at the Tampa Municipal Hospital, which was largely attended by some very prominent surgeons from various parts of the world. There was a special called meeting in May to hear Bela Schick on "Tuberculosis in Children." Dr. Deryl Holt of Duke University read a very interesting paper on "Our Sterilization in the Operating Room," with report of one thousand operations with results. The past president before retiring appointed a Committee to meet with one of the Latin societies of Tampa at their request to see if some basis of cooperation could be reached. There has been no report as yet. Six new members were received into the Society during 1938 and three members were lost by death. The Society is attempting to rid itself of factional politics and do some real work.

The December meeting was the annual election of officers, which resulted as follows: president, J. W. Alsobrook; vice president, T. C. Maguire; secretary, Jas. Grable, re-elected.

The Pinellas County Medical Society is probably one of the most active in the state, holding semi-monthly meetings during the winter and monthly meetings in the summer. The scientific programs are well worked out, with a featured paper by a member or a guest at each meeting. A complete report has been received from the secretary of this society, listing the meeting dates for 1938 and the scientific papers presented, which has been placed on file. This society has reported 87 active and 2 honorary members for 1939. Its officers are: president, E. C. MacCordy; first vice-president, N. W. Gable, Jr.; second vice-president, C. B. Wright; secretary-treasurer, W. C. McConnell.

### NINTH DISTRICT—

WALTER C. PAGE, M.D. .... *Cocoa*  
Brevard, Lake, Orange, Osceola, Seminole.

The Ninth Councilor District is composed of the five counties of Brevard, Lake, Orange, Seminole and Osceola. Four of these counties, namely, Brevard, Lake, Orange and Seminole have active and efficient county societies, while Osceola physicians divide their membership between the counties of Orange and Brevard.

It is a pleasure to report that the membership of the whole district, numbering 113 is 100 per cent paid up for the past fiscal year of 1938.

In this district we have 27 physicians, or about 20 per cent who are not connected with organized medicine. However many of these are listed as retired, though there are a few who can not or will not meet the requirements for membership in their various county societies. Also we have five active colored physicians in this district doing good work among their people.

Our second annual District meeting was held at Eustis on November 10, 1938, as the guest of the Lake County Society and the Lake County Medical Center. The attendance was good: the registration was 70, of which 50 were Association members, 43 were from this district, with 5 visitors and 15 ladies. This meeting was a complete success. Four excellent papers were presented and discussed. Several chairmen of standing committees of the State Association made reports, and interesting talks were made by several past presidents of the State Medical Association who were present. Dr. W. Henry Spiers, the State President, addressed the meeting on organization subjects.

The evening was given over to a banquet at the Lake County Medical Center, which was concluded by an address by the guest speaker, Dr. Wm. Perrin Nicolson, of Atlanta, who spoke on "Cancer of the Breast." Dr. H. D. Clark, the District President and Senior Councilor was prevented from attending by illness.

I feel that I can report that organized medicine is both healthful and useful in the Ninth Councilor District, and that we are maintaining the high ideals that the State Medical Association rightfully requires.

During the year I have attended the various meetings of the council, when summoned by the President.

In closing, I want to thank the president, Doctor Spiers; Secretary, Dr. Richardson; and the managing Director, Dr. Stewart Thompson, for their uniform courtesy and help during the past year.

#### TWELFTH DISTRICT—

HARRISON A. WALKER, M. D. . . . . *Miami Beach*  
Dade, Monroe.

There are two counties in Councilor District No. 12—Dade and Monroe. At the end of December, Dade County Medical Society had a membership of 282 and Monroe County Medical Society a membership of 4.

While there are only two counties in this Councilor District, the membership of the State Association is well represented since Dade County Society enjoys, at the present time, the largest membership of any county medical society in the state. A new Constitution and By-Laws was adopted by this society and the organization was incorporated not-for-profit. This was accomplished after a committee had spent many months in deliberation and the society now feels that it has a Constitution and By-Laws adaptable to a society of its size.

Monroe County Medical Society has a small membership but is very much encouraged at this time. One new member joined recently and the new bridge connecting the island with the main part of the state will undoubtedly be the means of increasing activities in organized medicine in that section.

The Southeast Medical District's second annual meeting was held at Fort Lauderdale in October. This Medical District comprises Councilor Districts 11 and 12. This was a very fine meeting.

As Chairman of the Council, I desire to express appreciation to every councilor. Your twelve councilors have made a real contribution to organized medicine.

#### STATE NEWS ITEMS

The Southeastern Surgical Congress announces the Tenth Anniversary Postgraduate Assembly, to be held in Atlanta, March 6-9, 1939 at the Biltmore hotel. A most interesting program has been arranged. Outstanding speakers from many states have already been secured.

On the preliminary program, the names of two Florida doctors appear: Dr. T. Z. Cason, Jacksonville, whose subject is "Medical Pathology Simulating Acute Surgical Conditions—Differential Diagnosis"; and Dr. J. G. Lyerly, Jacksonville, his subject being "Transection of the Prefrontal Lobe Association Fibres in Certain Mental Disorders."

For further information, write Dr. B. T. Beasley, Secretary, 701 Hurt Building, Atlanta, Ga.

Dr. C. E. Tumlin of Miami, after a six months' disability from a fractured spine, is now reported able to go back to work.

\* \* \*

Dr. L. C. Gonzales, Director of Venereal Disease Control of the Florida State Board of Health, gave an illustrated lecture at a meeting of the Florida Alpha Chapter of Alpha Epsilon Delta, national honorary pre-medical fraternity at the University of Florida, Gainesville, on January 9, 1939. Dr. Gonzales spoke on the subject of "Methods to Control Venereal Disease in the United States."

\* \* \*

Dr. O. W. Britt, radiologist at the Florida State Hospital, Chattahoochee, recently resigned to enter private practice in Tallahassee.

\* \* \*

Dr. R. G. Tietze of Miami Beach has recently moved to Winter Haven where he will be associated in practice with Dr. R. E. Gilbert.

\* \* \*

Dr. K. K. Waering of Jacksonville was appointed director of the Duval County Health Unit last November. Doctor Waering's appointment was approved by the Duval County Medical Society.

\* \* \*

The dramas in the series of weekly radio programs by the American Medical Association and the National Broadcasting Company for March, have been announced, as follows:

March 1—Diabetes.  
March 8—Water, Waste and Sanitation.  
March 15—Guarding Fresh Foods.  
March 22—Auditing the Health Record.  
March 29—Animal Diseases Transmitted to Man.

This program is broadcast over the Blue network of N. B. C. each Wednesday at 2 p. m., e. s. t.

\* \* \*

Dr. and Mrs. O. C. Brown of Ft. Lauderdale spent the Christmas holidays with their son-in-law and daughter, Dr. and Mrs. Paul S. Woodall of Birmingham, Ala.

\* \* \*

For the information of the Association's members, Dr. W. Henry Spiers, president, announces a change in the personnel of the Committee on Legislation and Public Policy. Dr. Horace A. Day of Orlando is now chairman; Dr. S. E. Driskell of Jacksonville suc-



ceeds Dr. Gerry R. Holden; and Dr. W. Duncan Owens of Miami Beach succeeds Dr. T. O. Otto. The names of the members of the Association's Committee on Legislation and Public Policy are shown on page 400 of this Journal.

\* \* \*

#### BIRTHS

Dr. and Mrs. Edwin P. Preston of Miami Beach announce the birth of a son on December 31, 1938.

Announcement has just been received from Dr. C. E. Tumlin of Miami of the birth of his granddaughter, Patricia, to Mr. and Mrs. Curtis Haggard, December 14, 1938.

\* \* \*

#### DEATHS

Dr. A. C. Knight of Jacksonville, died on February 12, following a brief illness.

### COMPONENT COUNTY SOCIETIES

#### BROWARD COUNTY MEDICAL SOCIETY

Dr. I. H. Agos of Miami was guest speaker at a meeting of the Broward County Medical Society held December 28. His subject was "Newer Methods of Treatment of Dementias."

\* \* \*

#### DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society held its regular meeting on the evening of January 3, in the Ingraham Building. The scientific program consisted of two papers: "Pathogenesis of the Diseases of the Anal Region" by Dr. Claude G. Mentzer (discussed by C. Larimore Perry and George D. Lilly), and "Intravenous Anesthesia with Pentothol Sodium" by Dr. Colquitt Pearson (discussed by George C. Austin).

\* \* \*

#### DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its first meeting of the year on the evening of January 3 in the Library of the State Board of Health Building, with the new president, Dr. Thomas E. Buckman, presiding.

The scientific program was presented under the direction of Dr. George Croft and included a paper by Dr. Karl Hanson on "Fluid Balance," (discussed by Drs. J. G. Lyerly and Julian E. Gammon), and an article by Dr. C. C. Mendoza on "New Techniques in Blood Transfusion," illustrated by motion pictures.

The president appointed a special economics committee composed of Drs. T. S. Field, Chas. B. Mabry, Kenneth Morris and Luther W. Holloway. Dr. Clayton E. Royce was named as the society's member of the City Planning Advisory Board.

\* \* \*

#### HILLSBOROUGH COUNTY MEDICAL SOCIETY

The Hillsborough County Medical Society was honored by the presence of Dr. Hugh H. Young of Baltimore, on January 31. Doctor Young presented a paper on "Some Medical and Surgical Problems in Urology," demonstrated with colored motion pictures. There were approximately 150 doctors in attendance.

Doctor Young spent several days in Tampa as the house guest of Dr. James L. Estes.

\* \* \*

#### JACKSON COUNTY MEDICAL SOCIETY

At the annual meeting of the Jackson County Medical Society, the following officers were elected: president, C. J. Price, Alford; vice president, C. C. Box, Graceville; and secretary-treasurer, R. N. Joyner, Marianna. Dr. R. L. Miller of Graceville was elected delegate to the next State Association meeting with Dr. D. A. McKinnon of Marianna as alternate.

\* \* \*

#### LEON-GADSDEN-LIBERTY-WAKULLA-

#### JEFFERSON COUNTY MEDICAL SOCIETY

The annual meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held January 19, at Chattahoochee. The following officers were elected: president, W. W. Massey of Quincy; vice president, F. T. Holland of Tallahassee; and secretary-treasurer, B. A. Wilkinson of Tallahassee. Drs. J. C. Robertson and B. A. Wilkinson were selected as delegates to the next State Association meeting, with Drs. W. W. Massey and F. T. Holland as alternates.

The following program was presented: "Remarks on Acute Appendicitis Based on Personal Experience," by J. S. Turberville, Century (discussion opened by J. C. Davis, Quincy); "Psychoanalysis," William H. McCullagh, Jacksonville (discussion by W. G. Miles, Chattahoochee); "Test of Liver Functions," W. P. Stowe, Chattahoochee (discussion by E. R. Annis, Tallahassee.)

Dr. W. Henry Spiers, president of the



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State Association, addressed the group at the dinner which followed the meeting. Thirty-eight members and guests were present.

\* \* \*

#### MANATEE COUNTY MEDICAL SOCIETY

The Manatee County Medical Society heads the Honor Roll for 1939 by being the first of the component societies to report 100 per cent dues for this year. The officers of this society are: president, Samuel Hollingsworth, Bradenton; vice president, Blake M. Lancaster, Manatee; secretary-treasurer, M. M. Harrison, Bradenton. Congratulations, Manatee County Medical Society.

\* \* \*

#### PALM BEACH COUNTY MEDICAL SOCIETY

The Palm Beach County Medical Society held its regular monthly meeting at the Good Samaritan Hospital Nurses' Lodge on January 22. The attendance was 68.4 per cent.

After the usual business meeting an interesting paper was given, illustrated by slides, by Dr. A. W. Adson of the Mayo clinic on "Spinal Cord Tumors, Their Diagnosis and Treatment." Dr. W. S. Lemon, also of Mayo Clinic, collaborated in this presentation.

Dr. Otto Hansen, Valley Springs, S. Dak. was also a guest of the Society at this meeting.

\* \* \*

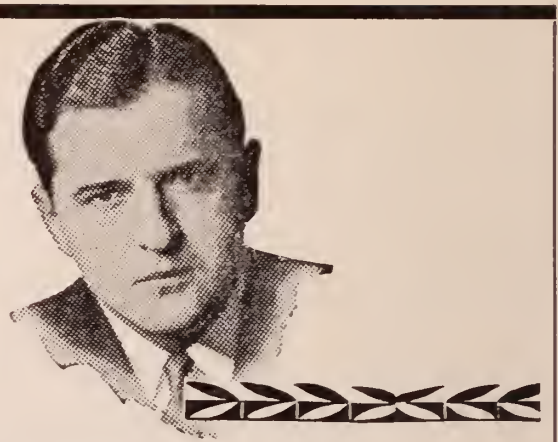
#### PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. W. H. Walters entertained the Pasco-Hernando-Citrus County Medical Society at his home in Lacoochee, Thursday evening, January 12. Dinner was served, consisting of roast duck, fried quail, and baked Virginia ham, with all the accessories that go to make a complete banquet.

After the business meeting, interesting case reports were given by Drs. J. T. Bradshaw, S. C. Harvard, H. L. Harrell, D. B. Manley, W. W. Jones, and W. H. Walters.

Those present were Drs. J. T. Bradshaw, C. L. Carter, H. L. Harrell, S. C. Harvard, W. W. Jones, D. B. Manley, W. H. Walters, R. D. Sistrunk, and G. R. Creekmore.

Doctor Creekmore invited the Society to hold its next meeting with him in Brooksville on the evening of February 9.



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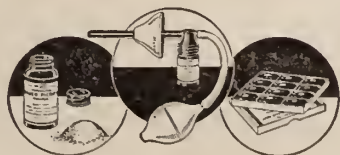
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## PINELLAS COUNTY MEDICAL SOCIETY

At the meeting of the Pinellas County Medical Society held at the Chatterbox, January 6, Dr. C. C. Rudolph was principal speaker. His subject was "Abstracting for the Journal of the Florida Medical Association."

The meeting scheduled for January 28, at which Dr. Russell LaFayette Cecil, Professor of Medicine at Cornell, was to have been guest speaker, was cancelled because of death in the family of Doctor Cecil.

\* \* \*

## PUTNAM COUNTY MEDICAL SOCIETY

The Putnam County Medical Society held its annual meeting at the Marian Hotel, Palatka, on the evening of January 10. The election of officers resulted as follows: president, E. W. Ford, Crescent City; C. M. Knight, Palatka, secretary-treasurer. Members present were: Z. Brantley, Grandin; E. W. Ford and J. E. Rose, Crescent City; F. Emory Bell, C. M. Knight, H. A. Johnson, and Allen P. Gurganius, Palatka.

\* \* \*

## ST. LUCIE-OKEECHOBEE-INDIAN RIVER-

## MARTIN COUNTY MEDICAL SOCIETY

At the election of officers of the St. Lucie-Okeechobee-Indian River-Martin County Medical Society held January 19, the following were chosen: president, J. D. Parker, Stuart; vice president, F. A. Gowdy, Ft. Pierce; and secretary-treasurer, A. M. Sample, Ft. Pierce. Dr. H. D. Clark of Ft. Pierce was elected delegate to the next State Association convention.

\* \* \*

## VOLUSIA COUNTY MEDICAL SOCIETY

The regular monthly dinner and business session of the Volusia County Medical Society was held January 10 at the Hotel College Arms, DeLand. Dr. Maximilian Stern of Daytona Beach, president of the Society, presided. Plans for the entertainment of the State Association next May were discussed. Dr. M. J. Myres of Daytona Beach read a paper on "Prevention and Cure of Diphtheria."

\* \* \*

## WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

The Walton-Okaloosa County Medical Society has become the second society in the state to report 100 per cent dues for 1939. Congratulations!

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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Mango Dermatitis, KIRBY-SMITH, J. L., Jacksonville, *Am. J. Trop. Med.* 18: 373-390 (July), 1938.**

Kirby-Smith, by means of patch tests, using the juice of stem and peeling of Brooks and Haden mangoes, found that 5 of 35 volunteers showed varying degrees of dermatitis and concludes that in a susceptible individual, contact will result in skin irritation.

It is also noted that Mango and Rhus belong to the same botanical family—*Anacardiaceae*.

A voluminous tropical correspondence reveals a diversity of opinion as to the existence of the condition in different and the same communities. However, the author suggests "that the attention of the physician reporting has not hitherto been drawn to the mango as the cause of the cases of dermatitis he encounters."

**Prolonged Coma in Insulin Treatment of Dementia Praecox, BENZLEY, R. F., Brentwood, N. Y.; and ANDERSON, J. L., Miami, *Psychiatric Quart.* 12: 477-488 (July), 1938.**

Prolonged coma, an interesting but embarrassing occurrence occasionally met in the course of hypoglycemic shock therapy, is discussed and four cases are reported.

Its occurrence is unpredictable and, peculiarly, continues in the presence of a normal or high blood sugar. Hence the natural tendency to crowd carbohydrate is useless.

The authors note the generally accepted view that benefit of hypoglycemic shock therapy is dependent on the production of relative anoxemia of neurological cells, probably most marked in structures of highly specialized function. This process is usually easily reversible by the administration of carbohydrate. However, in occasional cases the process is irreversible due probably to an actual encephalopathy, with irreparable cellular damage dependent on interference with normal oxidative processes.

In brief, the patient who has received the regularly prescribed dosage as determined for



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**GYNECOLOGY**—Two-weeks' Course starting February 27, 1939. Clinical and Personal Courses starting every week.

**OBSTETRICS**—Two-weeks' Intensive Course starting March 13, 1939. Informal Course starting every week.

**FRACTURES AND TRAUMATIC SURGERY**—Informal Course every week; Intensive Ten-day Course starting February 13, 1939.

**OPHTHALMOLOGY**—Two-weeks' Intensive Course starting April 24, 1939. Informal Course starting every week.

**OTOLARYNGOLOGY**—Two-weeks' Intensive Course starting April 10, 1939. Informal Course starting every week.

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Treatment after the initial administration of glucose, consists mainly in combatting symptoms as they arise and the maintenance of adequate nutrition.

**Physical Methods of Fever Production from a Physiologic Point of View, PHILLIPS KENNETH, Miami, *Arch. Phys. Therapy*, 19: 473-483 (August), 1938.**

Phillips discusses the physiological principles of fever production and emphasizes the fact that the preferred method of fever therapy is one which will heat the blood stream with the least amount of injury to other tissues or organs.

Of the two methods of heat production, radiant and penetrating, preference is shown for the latter and electro-magnetic induction seems to be the method of choice in that maximum heating takes place at an electrolyte concentration of 0.85 which is near that of the blood stream. Hence, this form of heat will tend to seek the blood stream in preference to other tissues of lower electrolyte concentration.

### BOOKS RECEIVED

*Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**WHAT'S WRONG WITH ME?** By H. AMEROY HARTWELL, M.D. A book written for laymen, listing the usual symptoms of about 200 of the more common disease entities, and giving cause, when known. The author, in submitting this volume for review, states: "Meakins, in his *Practice of Medicine*, says: 'When one comes to analyze the symptoms complained of by his patients, one is impressed by their poverty of description and how little they really know of themselves.' My object in presenting this volume to the public is to enlarge that vocabulary, and to supply an informative basis for self-analysis." Cloth, pp. 246. Garden City, N. Y.: The Country Life Press.



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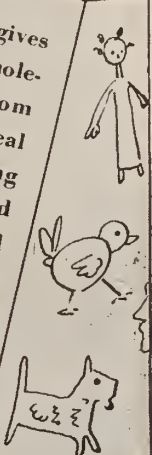
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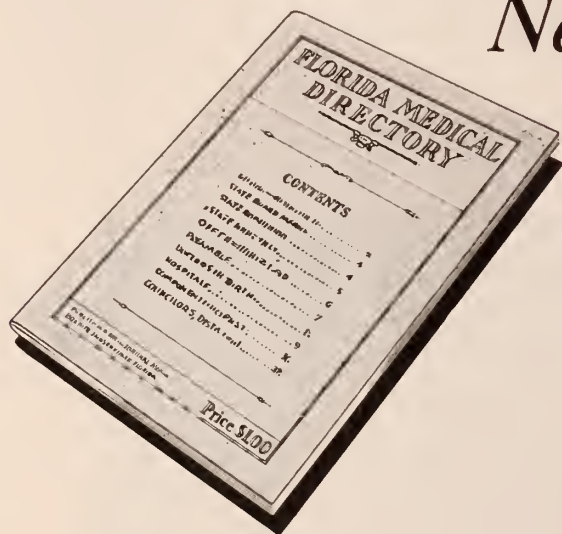
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## STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	W. Henry Spiers, Orlando.....	Shaler Richardson, Jacksonville....	Daytona Beach, May 1, 2, 3, 193
Florida Medical Districts:			
A—Northwest .....	Carol C. Webb, Pensacola .....	Stewart Thompson, Jacksonville....	Marianna, July 21, 1939
B—North Central .....	J. L. Strange, McIntosh .....	" " " .....	Ocala, Oct. 27, 1939
C—Northeast .....	George M. Green, Daytona Beach .....	" " " .....	Palatka, Sept. 15, 1939
D—Southwest .....	Herman Watson, Lakeland .....	" " " .....	Lakeland, Sept. 29, 1939
E—South Central .....	W. C. Page, Cocoa .....	" " " .....	Sanford, Nov. 10, 1939
F—Southeast .....	Lloyd J. Netto, West Palm Beach .....	" " " .....	West Palm Beach, Oct. 13, 1939
Alabama Medical Association.....	Seale Harris, Montgomery .....	D. L. Cannon, Montgomery .....	Montgomery, Apr. 18-20, 1939
Georgia Medical Association.....	Grady N. Coker, Canton .....	E. D. Shanks, Atlanta .....	Atlanta, May 9-12, 1939
Florida—			
State Dental Association.....	R. P. Taylor, Jacksonville .....	E. C. Lunsford, Miami .....	West Palm Beach, Oct. 12-14, 1939
Soc. of Derm. and Syph.....	Elmo D. French, Miami .....	Lauren Sompayrac, Jacksonville....	Tampa, May 1, 1939
East Coast Medical Association.....	Fredrick J. Waas, Jacksonville....	A. J. Logie, Jacksonville .....	Jacksonville, 1939
State Hospital Association.....	Gertrude Overstreet, Gainesville .....	Mr. Fred Walker, Jacksonville....	Jacksonville, Apr. 13-15, 1939
Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville....	Chairman .....	Daytona Beach, June 19-24, 1939
State Nurses Association.....	Mrs. Inez Nelson, Orlando .....	Mrs. Phyllis Leonard, St. Augustine .....	Lakeland, Nov. 6-8, 1939
Pediatric Society .....	Gilbert S. Osincup, Orlando .....	Warren Quillian, Coral Gables .....	Daytona Beach, May 1, 1939
Pharmaceutical Association .....	Mr. R. Q. Richards, Ft. Myers .....	Mr. A. W. Morrison, Miami .....	Hollywood Beach, May, 1939
Public Health Association .....	Mr. S. D. Macready, W. P. Beach .....	E. M. L'Engle, Jacksonville .....	Jacksonville, 1939
Radiological Society .....	H. O. Brown, Tampa .....	J. H. Lucinian, Miami .....	Daytona Beach, May 1, 1939
Railway Surgeons Association.....	Herman Watson, Lakeland .....	H. D. Clark, Ft. Pierce .....	Daytona Beach, May 1, 1939
Tuberculosis & Health Assn.....	Mr. G. E. Therry, W. Palm Beach .....	Mrs. May Pynchon, Jacksonville....	Spring, 1939
Chattahoochee Valley Med. Assn.....	J. S. Turberville, Century .....	Frank K. Boland, Atlanta .....	Albany, Ga., July 11-13, 1939
Gulf Coast Clinical Society.....	J. H. Dodson, Mobile .....	C. C. Rouse, Mobile, Ala. ....	Mobile, 1939
Southeastern Derm. Assn.....	J. R. Allison, Columbia .....	Howard King, Nashville .....	Nashville, Sept. 3, 1939
Southeastern Surgical Congress.....	T. C. Davison, Atlanta .....	B. T. Beasley, Atlanta .....	Atlanta, Mar. 6-8, 1939
Southern Medical Association.....	W. E. Vest, Huntington, W. Va. ....	Mr. C. P. Loran, Birmingham .....	Memphis, Nov. 21-24, 1939
Suwannee River Medical Society.....	E. C. Chamberlain, Madison .....	Eustace Long, Madison .....	



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COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

Dis- tricts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not In- cluded in First Column	Members	
						Total	Paid
Northwest District (A) Marianna July 21, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	11	
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. Desoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	24
	Walton-Okaloosa	A. G. Williams, M.D. Lakehood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M.D. Veruon	R. H. Segrest, M.D. Bonitay		<i>Santa Rosa</i>	8	
	Franklin-Gulf	Chapman Dykes, M.D. Carabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'39 N. A. Baltzell, M.D. Marianna	7	
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		14	9
	Leon-Gadsden-Liberty- Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	<i>Calhoun</i>	36	1
North Central District (B) Ocala October 27, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Dianche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M.D. Lake City	19	9
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Ralph J. Greene, M.D. Perry	W. J. Baker, M.D. Poley	Last Friday 8:00 P. M.	<i>Baker-Dixie-Hamilton- Lafayette-Suwannee</i>	8	
	Alachua	J. E. Malnes, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 553 W. Main St. S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	29	
	Marion	Carl S. Lytle, M.D. Dunneilon	It. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		22	10
	Pasco-Hernando- Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	13
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	<i>Bradford-Gilchrist- Levy-Union</i>	3	2
N. E. District (C) Palatka September 15, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M.D. Jacksonville	169	77
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	<i>Clay-Nassau</i>	11	
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	10	6
	Volusia	Maximilian Stern, M.D. Box 5098 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	<i>Flagler</i>	38	
Southwest District (D) Lakeland September 25, 1939	Hillsborough	J. W. Alsobrook, M.D. 120 N. Collins St. Plant City	James G. Grable, M.D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M.D. Plant City	104	
	Manatee	S. G. Hollingsworth, M.D. Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.		14	100%
	Pinellas	E. C. MacCordy, M.D. 627 11th St. N. St. Petersburg	W. C. McConnell, M.D. 1005 Equitable Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		90	75
	Sarasota	T. W. Taylor, M.D. Walpole Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	
	DeSoto-Hardee-High- lands-Charlotte- Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M.D. Lakeland	20	
	Lee	C. Gordon Merrick, M.D. 26 Leon Bldg. Fort Myers	H. L. Allen, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		13	
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	<i>Collier-Hendry</i>	61	
South Central District (E) Sanford November 10, 1939	Brevard	G. E. Christie, M.D. Titusville	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	12	
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		76	
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	<i>Osceola</i>	13	
	St. Lucie-Okeechobee Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M.D. Ft. Pierce	17	15
S. E. District (F) West Palm Beach October 13, 1939	Broward	R. L. Elliston, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	31	
	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Harvey Bldg. W. Palm Beach	4th Monday 8:00 P. M.		58	
	Dade	M. Jay Filpse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M.D. Miami Beach	282	
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	

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VOLUME XXV  
No. 9

Jacksonville, Florida, March, 1939

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Florida Medical Association, Daytona Beach, May 1, 2, 3, 1939  
Southern Medical Association, Memphis, November 21-24, 1939

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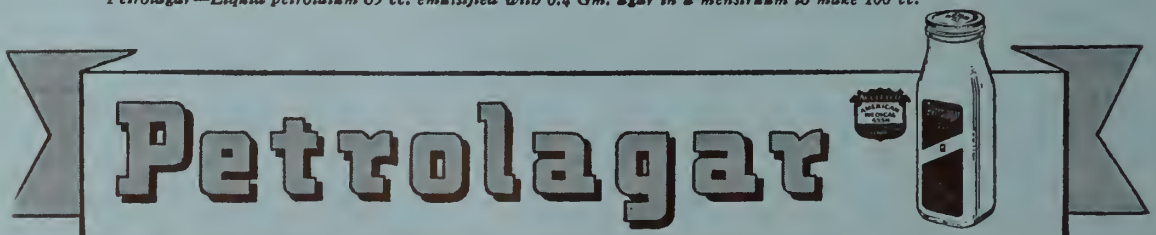
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## VII. The Unknown Vitamins

● The past twenty years of biochemical research have steadily brought additions to the list of vitamin factors known to be indispensable in proper human nutrition. Today, only vitamins A, B<sub>1</sub>, C and D, riboflavin and the P-P factor are universally considered as essential to man. In general, the requirement for these factors is greater in certain phases of the human life cycle than in others.

This list of essential factors is probably incomplete. It has been aptly stated (1) that our species has evolved in the direction of lengthening rather than shortening the list of known dietary essentials. However, it is reasonable to believe that the above list, although incomplete, probably does include all factors whose absence from the ration may cause the most severe types of human dietary deficiency disease.

Investigations on the nutritive requirements and the biochemistry of the lower forms of animal and plant life constitute the frontiers of modern vitamin research. From studies such as these may come the first clues as to new vitamins which may ultimately be proven essential in human nutrition. For example, it was upon research of this type that the dietary requirement of the rat for riboflavin was established and

the importance of riboflavin (1) in human nutrition postulated.

During recent years, a large number of factors essential to animals other than man has been enunciated (2). As examples might be mentioned the factor in plant juices required by herbivora (3); the factor in fresh meat essential to trout (4); and vitamin K, needed for normal blood coagulation in fowls (5). Whether these or others of the factors essential to lower forms of life will also prove indispensable to man, the future must decide.

The knowledge that our present list of essential vitamins may be incomplete, need not be alarming. However, such knowledge should serve to emphasize the desirability of a diet formulated according to the best present concepts of the science of nutrition. Nature intends that man should receive all dietary essentials, known or unknown, through food and it will be through the medium of a judiciously chosen, varied diet that these essentials can best be obtained. Needless to state, the several hundred varieties of wholesome, nutritious, commercially canned foods lend themselves admirably to formulation of such varied, protective diets.

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(1) 1938. J. Amer. Med. Assn. 110, 1278.

(2) 1938. Ibid. 110, 1441.

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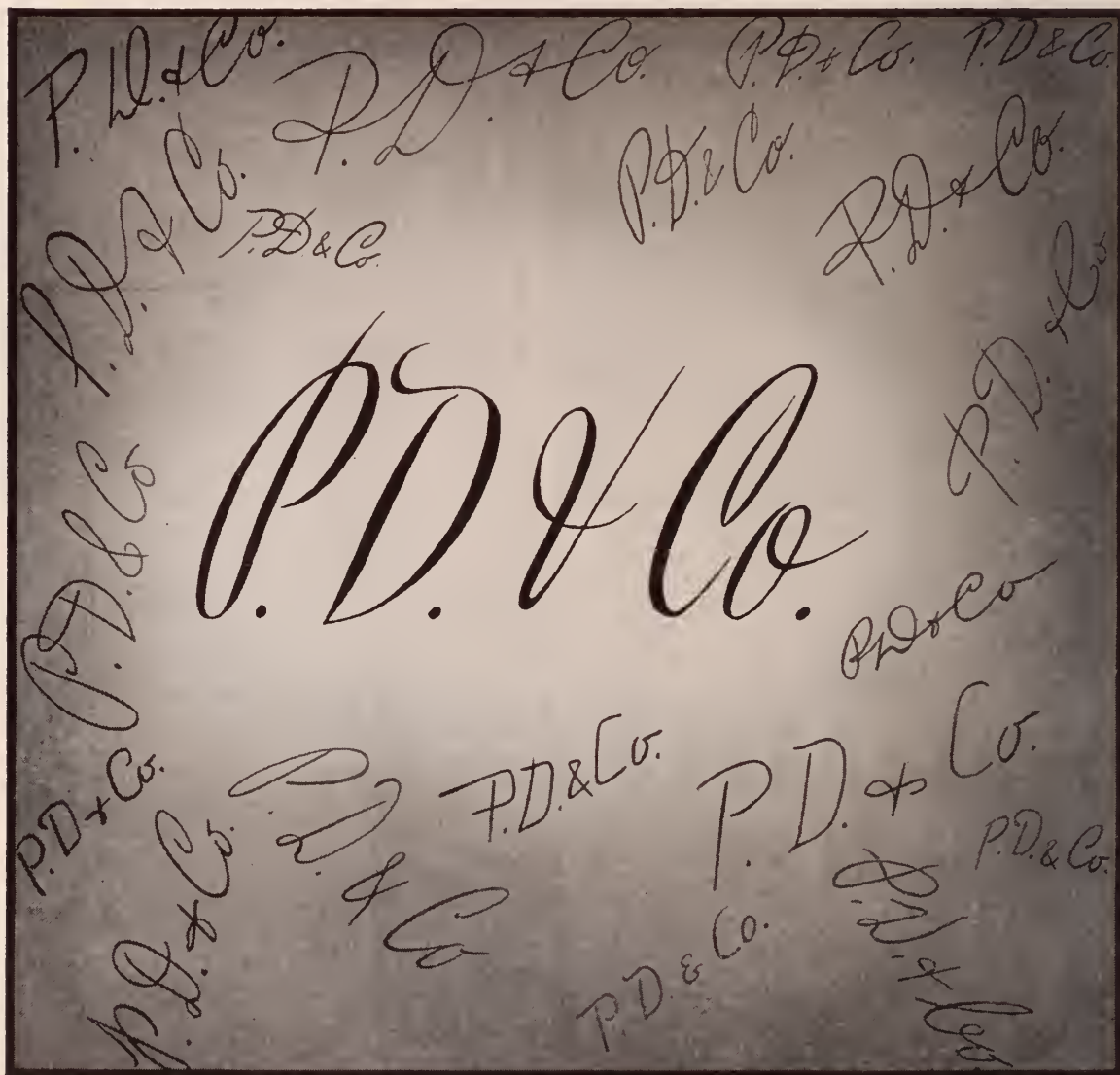
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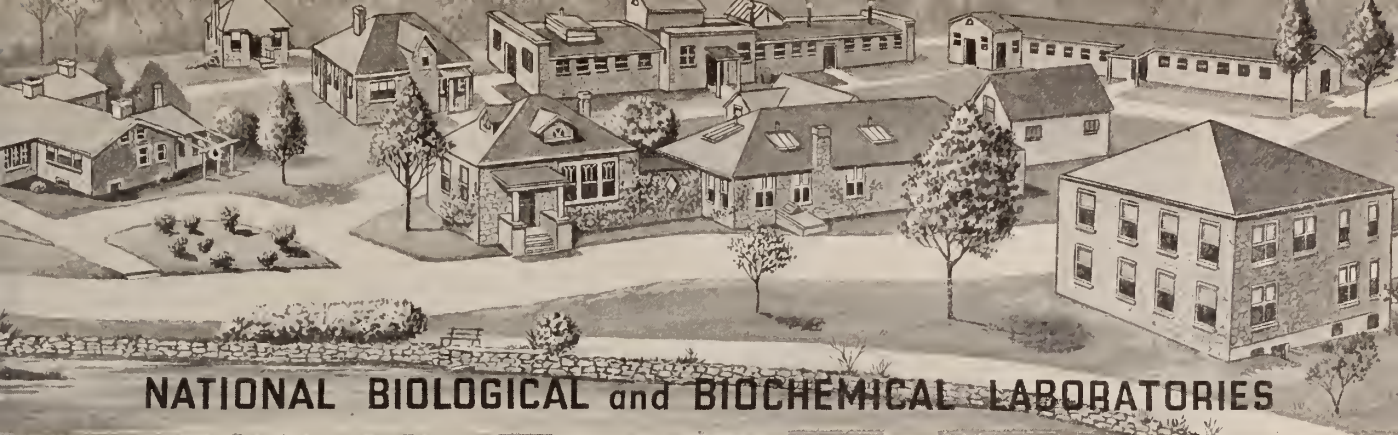
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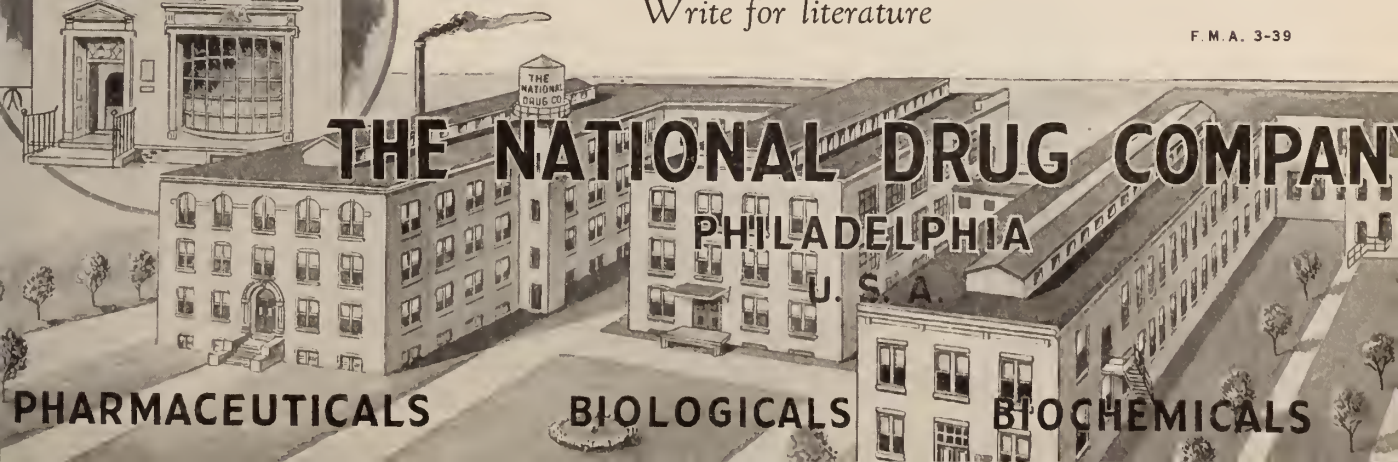


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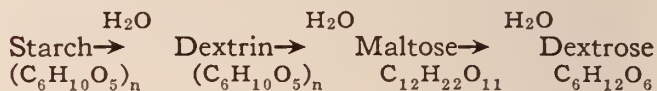
2. Q. What are the Karo equivalents?

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## STERILITY

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One of the more recently developed studies in the field of gynecology and obstetrics is the subject of sterility, or the inability of a married couple to produce offspring. For a number of years we have listened to the requests of barren couples who have sought advice relative to their problems, but either because of lack of knowledge or lack of interest, the doctors have offered no real solution.

The subject of sterility is important to every married couple, whether desirous of children or not. Recent studies on the theory of ovulation are beginning to show the relative "safe periods" in the menstrual cycle, and by satisfactory explanation to the married partners and by intelligent cooperation on their part, reasonable results may be expected in the proper spacing of pregnancies.

There are many classifications of sterility but, in my own work, I have found it simpler and less confusing to divide the subject into two classes, primary and secondary.

The class of primary sterility includes those individuals who have been, apparently for congenital reasons, unable to become pregnant. In this classification are also grouped the endocrine cases, such as hypothyroid or hyperthyroid cases, the hypo-ovarian cases, the amenorrheas, the infantile sexual developments, the congenital atresias, and the cases of non-infectious pathology of the pelvic organs such as fibroid uterus and ovarian tumors.

The secondary or acquired classification includes those cases which are largely due to infections at some time in the patient's life. Under this classification will come the cases of the so-called "one-child sterility," in which one pregnancy has occurred but subsequent pregnancies are impossible. Also in this classification will come the visibly pathologic cases, such as lacerated perineums, lacerated and infected cervixes, uterine displacements and the chronic pelvic inflammatory diseases.

While my work is entirely confined to the subject of sterility in the female, it is most important to consider that the husband plays an important role and it is necessary that he be able to produce normal live active sperm in order to impregnate his mate. Therefore, no examination of sterility is complete unless a thorough study is given the male partner. If any deviation from the normal is noted in the examination of the sperm, the husband is referred to the urologist and internist for their consideration.

When the patient presents herself for examination, a complete history is obtained. In this history is included a complete menstrual history relative to the onset, regularity, type, duration and amount of flow. Every patient is asked to note the intermenstrual cramps, if present, which are indicative of the ovulation period in that particular individual. Illnesses, major and minor, including childhood diseases, particularly mumps and scarlet fever, are gone into. Past operative procedures, particularly those related to the lower abdomen and pelvic organs, are carefully studied. A complete physical examination is done on every patient in order to rule out any possible foci of infection and to pick up any anatomical defect. If any pathology is found, efforts are made to have the condition corrected. In this physical examination are naturally included the usual blood and urine studies. Examination is next directed to the pelvis. A careful pelvic examination is done to note the condition of the perineum, cervix, position and size of the uterus, and the condition of the adnexa. If any pathology is found, the usual procedures to correct the condition present are undertaken.

It is important to include a basal metabolism test on every sterility subject. Because of the distinct relationship between the ovaries and the thyroid no examination can be complete without a satisfactory knowledge of the thyroid function of that particular patient. The technic of the Rubin test as I carry it out is fairly simple. Carbon dioxide gas is used because of the quick absorption in the peritoneal cavity. The apparatus consists simply of a carbon dioxide tank with a control needle

valve with a small Tycos manometer inset with a "Y" tubing between the tank and the cannula. The patient is put up in stirrups, the cervix exposed with a speculum, the vault of the vagina cleansed thoroughly with saline or wiped dry with cotton pledgets. Essence of caroid is used to thoroughly cleanse the cervix and lower cervical canal of mucus. The cervix and lower cervical canal is touched with tincture of merthiolate and the cannula with the acorn tip inserted into the cervical canal to make a tight fit.

In cases of retroversion, the position and direction of the canal is determined by passing either a dressing forcep or a small uterine sound into the canal and the cannula is turned so the curve follows the direction of the canal; otherwise the tip of the cannula may be pressing against the cervical canal thus preventing the proper escape of the gas. Before inserting the cannula in the cervical canal it is well to adjust the needle valve so that the manometer reading does not rise more than 120 mm. in fifteen seconds. A normal tube will permit the passage of gas into the abdomen at 120 mm. or below. Normal tubes can be readily observed by the reading. The needle of the manometer will go to 100 or 120 and then drop to 60 or 50 and remain at that level as long as the gas is allowed to flow, indicating the gas is passing into the abdomen. This is usually repeated for two or three short tests, each time the cannula being removed and reinserted. After the test the patient is allowed to sit up and if the tubes are patent, will complain of pain under the right or left shoulder, or both, or in the neck. This is due to the collection of the carbon dioxide under the diaphragm. This pain will either disappear entirely or be relieved by lying down which will shift the gas into the coils of the intestines where it is readily absorbed. The patient is able to leave the office in thirty minutes or less with no recurrence of pain. For this reason I have abandoned the use of air and use carbon dioxide entirely.

The Rubin test is best run within the first week after the cessation of menstruation as the endometrium is at its lowest ebb at that period. If the test is not done at this time there is likelihood that a false reading may be obtained or perhaps a normal uterine pregnancy may be interrupted. I have never had

any success with auscultation of the lower abdomen and hearing the gas pass through the tubes into the abdomen.

If normal patent tubes are found, I instruct the patient as to intercourse and as to the method to use in collecting the semen. The patient is asked to have intercourse with her mate in the morning at a specified time, and following intercourse to insert a small Wasermann tube into her vagina and collect some of the male secretion. The tube is then stoppered and strapped with adhesive to some part of her body to keep the semen at body temperature. She is asked to report at the office within one hour following intercourse. Semen is then collected from the vaginal vault and placed on a hollow ground slide and covered with a cover glass, the edges of which are sealed with vaseline. A specimen is likewise collected from the glass tube and a like procedure is done. Normally the sperm will remain alive and active, according to my observations, at least twelve hours at ordinary room temperature. I do not make observations after that length of time. A stained smear is also made of the sperm to determine the size and shape of the sperm.

If transplantation of the semen is desired, and if the test is run during the ovulation period of the patient, the technic is fairly simple. Using a tuberculin syringe, .2 cc. of the semen is used and .8 cc. of normal saline, drawing up the semen last so that it will be the first to be injected into the canal and washed in with the remaining .8 cc. of normal saline. The acorn tip cannula is used for the transplantation as the tuberculin syringe does not permit sufficient pressure to force the semen mixture beyond the uterine cavity.

Because of the low percentage of successful operative results on diseased tubes (818 plastic operations on the tubes followed by 36 live babies—a percentage of 4.4 as reported on page 357 of the 1937 Year Book on Obstetrics and Gynecology), one should not feel too enthusiastic about encouraging the undertaking of operative procedures in these cases of occluded tubes. It is for this reason that I do not use lipiodol injections in the uterine cavity and tubes. I can see no definite advantage in knowing just where the obstructing lesion is unless some encouraging operative procedure can be offered the patient. Also there is



the possibility of the lipiodol collecting in an obstructed tube with probable pelvic complications.

Recent studies, particularly those of Dr. Emil Novak, have shown that every menstruating woman has a definite ovulation time. By means of a suction curette, Doctor Novak as an office procedure, collects sections of the endometrium at varying times in the menstrual cycle, the changes in the endometrium indicating the ovulation time. Whether or not we undertake the microscopic determinations ourselves we have sufficient reason to believe and know that ovulation is a necessary factor for impregnation. Ovulation has been agreed upon by numbers of authorities on the subject to take place during the period of ten to eighteen days before the first day of the next menstrual period. Each patient can be asked to determine this period by herself in the following manner (a) intermenstrual cramps, slight but usually noticeable (b) greater sexual desire (c) greater sexual satisfaction (d) increased dampness to the perineum due to activity of the cervical glands (e) sometimes very slight spotting.

Antuitrin-S will stimulate the ovarian folliculation and I usually start my patients on 300 R. U. three days before the expected ovulation period and continue with 100 R. U. each day of the ovulation cycle, this procedure being done in the hope of stimulating active ovulation. Parke-Davis has recently marketed a stronger Antuitrin-S solution in a five cc. vial, each cc. containing 500 R. U. instead of the usual 100 R. U. and I hope that better results will be obtained with this product.

If the basal reading shows a minus result or if the symptoms are sufficient to warrant its use, regardless of the basal reading, the patient is given thyroid extract  $\frac{1}{2}$  to  $\frac{1}{4}$  of a grain three times daily for each minus five. In my own work I have secured best results by using Armour's Powdered Thyroid Extract and putting the prescribed amount in small capsules for the individual case. With this small amount of thyroid after several months, in the amenorrheic cases, marked increase in the amount and duration of the flow will be noted.

In those cases of secondary sterility, infections and lacerations of the cervix must be

cleaned up by the usual procedures. Endotherm conization of the cervix, properly done, makes a simple but thoroughly satisfactory procedure. Retroversions may be temporarily corrected by the use of a pessary until pregnancy can occur, and following the delivery of the desired number of children, a permanent suspension with ligation of the tubes can be done. If a suspension must be done and if the patient has patent tubes, the simple Alexander-Adams suspension of the round ligaments in the inguinal canals gives marked results. I think it is poor surgical judgment to open an abdomen to do a suspension for relief of sterility by suspending the uterus.

Quite a number of these retrodisplacements of the uterus with adhesions or those that seem firmly retroverted can be temporarily corrected in the office with the use of a Davol rubber ice cap inserted in the vault of the vagina and filled with mercury. The patient is placed in the Trendelenburg position, the Davol bag inserted in the vaginal vault and five to eight pounds of mercury poured in the bag. The mercury will find the hollow of the sacrum and wedge itself in between the fundus and the sacrum, thus lifting the fundus. The patient is left in this position for twenty to thirty minutes and experiences very little discomfort. It is really very surprising to examine the patient after this procedure and to find how high the fundus is riding. Personally, I have my first retroversion to see that was not relieved by this procedure.

In selected cases, those with a hypertrophy of the cervix with excessive mucoid secretion and those of mild lymphadenitis of the broad ligament with possibly edematous tender tubes, I have had excellent results with the Elliott heat treatments, usually giving about twenty treatments. The size of the cervix can be materially reduced, the tenderness produced by manipulation of the uterus and adnexa, and occasionally a blocked tube can be relieved. I do not believe the Elliott treatments can be used indiscriminately to advantage but in certain cases marked results can be readily noted. The treatment of the average case of sterility is not unusually difficult. It requires the patience of both the attending physician and the patient and without their full cooperation, even the minimum results cannot reasonably be expected.

Our recent forward steps in the field of gynecology and obstetrics, especially those investigations relative to the phenomena of menstruation, ovulation and endocrinology, have put us in a position to benefit this type of case. "No married couple, desirous of children, should be told that a barren marriage exists until both partners have been given careful study, and the results have been counter-checked. A couple may be basing their decision to adopt a child on the possibility of being able to overcome their sterility. Even under such circumstances and in the presence of what appears to be an absolute sterility, the prognosis should still be a guarded one avoiding a definite and final answer. The couple should be told that pregnancy is uncertain, or even unlikely under present conditions and be advised to proceed with the adoption. There are too many psychoneurotic factors centered around the instinct for reproduction to risk arousing these to a pathologic degree by a heedless and abrupt dismissal of hopes without the opportunity of gradual adjustment." \*\*

#### CASE REPORTS

The following case reports have been selected from my private practice to illustrate some of the results that can be obtained:

Case No. 1. Mrs. N. W., white, aged 27 years, weight 155¼ pounds, married four years, though she had used no preventatives for past three years, had no pregnancies. When examined on June 2, 1937, the Huhner and Rubin tests were normal; past history and pelvic findings essentially negative, except for slight but regular menstruation; basal reading, minus 13. This patient was put on ½ grain of Armour's Powdered Thyroid Extract four times daily. Her weight on October 1, 1937, was 148 pounds; general condition better; menstruation heavier and longer. The first day of her last menstruation was Feb. 22, 1938. Pelvic examination on April 25, 1938, showed patient apparently two months' pregnant. Friedman and Antuitrin-S tests were positive for pregnancy, confirming pelvic findings. This patient had been taking thyroid extract for eight months before her pregnancy had occurred. The use of thyroid extract will be continued during her pregnancy according to indications.

Case No. 2. M. B. H., aged 30, was a winter visitor from Canada. She was first seen in March, 1934, when she had an intestinal obstruction resulting from loops of ileum becoming entangled in the right round ligament following an Olshausen suspension of the uterus done in Montreal in November, 1933. The operative results were excellent for the relief of the obstruction. The Olshausen suspension had been done following three miscarriages all under four months, the attending physician at that time thinking a retroversion was responsible for the miscarriages. At the time of the op-

eration, her surgeon reported an infantile uterus and advised against the attempt at future pregnancies.

This patient was next seen December 11, 1936, giving her last menstrual period as November 4, 1936. The Antuitrin-S and Friedman tests were both positive for a pregnancy. Basal reading was minus 18 on December 14. She was placed on a ¾ grain of Armour's Powdered Thyroid Extract four times daily. She returned to her home in the early spring of 1937 and delivered a full term healthy baby girl on August 4, 1937. This patient was seen again on April 19, 1938. Her last menstrual period was February 18, 1938. She spotted slightly on March 30. Pelvic findings showed the uterus enlarged normally to a two months' pregnancy; the Antuitrin-S intradermal test was positive; basal reading minus four. The patient has returned to her home in Montreal. I believe this patient's prior miscarriages were due to a thyroid imbalance which was corrected by taking thyroid extract for the nine months of her first normal pregnancy.

Case No. 3. Mrs. G. B., aged 32 years, had had one full term pregnancy eight years previously but no pregnancies since, though no prophylactic measures had been used. Rubin test on June 25, 1935, showed non-patent tubes, manometer being carried to 200 mm., and sustained for five minutes. Pelvic examination showed a small tender mass at the end of the left tube in the lower left quadrant. Laparotomy done on July 6, which revealed the presence of cysts on fimbria of left tube, the cysts being the size of a large marble. Both tubes were opened with a grooved director and a small sound, the obstruction being found in the isthmus of both tubes. On September 30, November 14 and December 7, 1935, the Rubin test showed normal findings, gas passing through at 120 to 130 mm. and the patient having the usual pains under the shoulder. I did not see the patient again until December 26, 1936, when a Rubin test was run and the tubes opened at 190 mm. Two days later the tubes opened at 120 mm., the patient having pains under the shoulders on both occasions. On December 30 a Huhner test showed normal sperm. During the months of February and March of 1937 a series of twenty Elliott treatments were given and during the months of April, May and June the patient was given Antuitrin-S injections at her ovulation period. On September 7 and 8 the Rubin test was positive for patent tubes. The patient had her last normal menstrual period on October 12, 1937. On November 30, both Friedman and Antuitrin-S tests confirmed pelvic findings of a uterine pregnancy. The patient made the usual progress of a pregnancy until January 15, 1938, when she showed signs of an abortion. The night before she became very frightened by prowlers in the yard, the incessant barking of a huge police watch-dog, and the subsequent shooting of a double-barreled shotgun at the dog. Her husband was out of the city and she was alone at the time. She spent a very uncomfortable night and was in a highly nervous state the next morning, when she began to have lower abdominal cramps. She was immediately hospitalized, but despite massive doses of progesterone and lipolutein she went into active labor and aborted on January 18. This was an unfortunate interruption of a pregnancy that was proceeding normally.

Case No. 4. Mrs. H. T., aged 29 years, had been married five years with no pregnancies, though no contraceptives had been used for the past four years. This patient was first seen on July 27, 1936. Pelvic findings were negative with the exception of a mild chronic cervicitis and a cervical polyp which occluded the major portion of the external os. On July 31, an endotherm conization of the cervix was done to remove the polyp. The specimen report showed this to be a benign cervical polyp. On June 5, 1937, Rubin test showed normal patent tubes which opened at 120 mm. On October 26 the Huhner test was run and the semen examined every 30 minutes, the sperm remaining alive and active for nine hours, when observations were dis-

\*\*Quoted from Management of Obstetrical Difficulties—Titus—1937—page 68.



continued. The patient was given antophysin during the October, November and December ovulation periods. The cervix was dilated wide with graduated sounds in January at the beginning of the suspected ovulation period. On March 5 the patient presented herself for examination, the first day of the last period being January 25, 1938. The Antuitrin-S intradermal test was positive for a pregnancy on that date and pelvic findings on March 20 confirmed the findings of a normal uterine pregnancy. This patient was seen by me on April 12 and 26, and running a normal course.

Case No. 5. Mrs. A. W., aged 29, had a normal full term delivery in 1930. She presented herself for examination relative to the question of a second pregnancy on October 12, 1934. She gave a history of metrorrhagia (12 to 14 days) for the past year. The past history included a thyroidectomy done in 1928. Pelvic findings showed the presence of a left cystic ovary the size of a tennis ball, the cervix practically closed, barely admitting a No. 4 French sound. Both tubes and right ovary were normal by palpation. A Rubin test, run on January 14, 1935, showed both tubes closed at 200 mm., while in a test two days later, the tubes opened at 160 mm. on the third attempt. On February 20 the patient was in the office and stated that her last period was on January 10. The Friedman test was positive for pregnancy. The latter part of March, the family bought a new car and the industrious wife polished it thoroughly one afternoon. The following night she suffered acute lower abdominal cramps and at 2:30 the next morning had a spontaneous expulsion of a two months' pregnancy. Patient again returned to the office on October 28, 1935. Three tubal insufflations were done; the last test showed the gas passing through at 130 mm. The patient skipped her November and December menstruation, and despite the fact that her basal reading was within normal limits, she was placed on small doses of thyroid. Fetal movements were felt on March 12, 1936, and this patient delivered a full term normal baby boy on July 12, the pregnancy most likely occurring immediately after the tubal insufflation in October. In this particular case, it is remarkable that the patient went for over five years without becoming pregnant, no precautions being used, and then after only two insufflations, two successive pregnancies followed.

Case No. 6. Mrs. C. McL., aged 29, was first examined September 21, 1935. Her past menstrual history was negative; she had a full term normal delivery in 1929. She had remarried and was desirous of pregnancy by present husband. Pelvic examination (bimanual) revealed nothing of significance. Rubin insufflations, three attempts, carried to 200 mm. and held for three minutes each, did not open tubes. On November 26, 1935, the tubes were non-patent. A Huhner test run on this date showed normal sperm. This patient was not seen again until November 8, 1937. In the interim of two years she had been operated and the attending surgeon wrote me as follows: "Mrs. McL. was operated in March of this year (1937). The operative record reveals that she had some adhesions of both tubes and ovaries and that the fimbriae were sealed with apparently soft adhesions. The uterus was somewhat retroverted. We opened each fimbria and insufflated each tube with an aseptic syringe leaving the fimbria apparently normal. I gave her a favorable prognosis for pregnancy after the operation. I am sorry she is still having trouble and had hoped that she would have conceived some time ago." In addition this patient stated that she had received some twenty Elliott treatments in the summer of 1937.

On November 8, 1937, the Rubin test was carried to 215 mm. and the tubes were not open. Two days later, the reading dropped from 190 to 170 mm. where it remained. On November 12, three tests were run and the last test which dropped to 150 showed gas apparently passing into the abdomen. The patient complained of slight pain under the shoulder after this insufflation. December 18 the patient was put in Trend-

elenburg position and after inserting the cannula into the cervix the vaginal vault was filled with sterile water. The test showed the Tycos needle slowly drop from 200 to 160 mm. There were no gas leaks at the cervix. On January 16, 1938, three insufflations showed the manometer reading drop from 150 to 110, the patient complaining of marked discomfort under the shoulders after the test. On March 11, three tests were run, the gas passing through at the 140 level and dropping to 100 mm. on shutting off the pressure. This patient was last seen on May 6. Tests showed that the tubes were definitely open at 120 mm. and fell rapidly to 70 mm. on shutting off the gas pressure. The patient showed the characteristic symptoms of pains under the shoulder which disappeared on lying down. She had been given 100 R. U. daily of Antuitrin-S by her attending physician in Tallahassee during the February, March and April periods. During the May ovulation period we have put her on the stronger Parke-Davis Antuitrin-S, which contains 500 R. U. per cc., every other day. I believe this patient will eventually become pregnant.

This case really exhibits the cooperation that a patient will render. She has driven over 500 miles each month for the past five months for the sole purpose of having a Rubin insufflation of her tubes. She has taken injections of Antuitrin-S for the past four months in an attempt to stimulate her ovulation. She received 20 Elliott treatments in the summer and early fall of 1937 and in March of 1937, at the advice of her attending physician, underwent a laparotomy in the hope of relieving her sterility. Finally, her last four Rubin tests during the past four months have shown her tubes to be patent.

*120 E. Robinson Street.*

## DISCUSSION

*Dr. John D. Milton, Miami:*

I wish to commend Doctor Hoffmann on his paper. It reveals considerable study and preparation and in discussing it I wish to stress three points.

First. Following the old adage that it takes two to make a baby, we must not underestimate the male side. Here I think consultation is necessary. The matter of normal male sperm must not be left to the observation of a technician. The pathologist should be the man to determine the two factors of the sperm, normal fertility and mobility. If either of these conditions are not normal the urologist has his hands full.

Second. I want to emphasize the endometrial study, that is the endometrial scrapings pre-menstrually done by Dr. Emil Novak to determine ovulation. I want to quote Dr. Sam R. Meeks of Boston: "The ovary must be mechanically free to liberate mature egg cells, but the gland must also be able to create the divine spark, that sum-total of hormones that endow the ovum with adequate vitality."

Third. In this modernistic age we must take into consideration contraceptives. Both



husband and wife should be educated along the lines of safe periods as stated by Dr. Hoffmann, and they also should be advised as to proper contraceptives so that after discontinuing their use, the vaginal mucous membrane will return to normal. This education should be secured from a medical man and not from a drug store window display.

In closing I wish to again congratulate Doctor Hoffmann on his paper.

*Dr. Russell B. Carson, Orlando:*

There are two points I would like to bring out from the viewpoint of the urologist. First, that one should not let the examination of the female—that is, of the sperm obtained from the female, be the only examination that is made of the sperm. The reason I say this is that in the ordinary routine examination of the sperm obtained from the vagina it is difficult to determine the number of sperm present. As you know at least 60 per cent of the normal number of sperm should be present if pregnancy is to be expected. Not infrequently one may find live sperm actively mobile, but after an examination is made of the sperm not mixed with vaginal secretion you may not find more than 10, 15 or possibly 25 per cent of the normal number of sperm present, and a goodly number of these may be abnormal forms.

Another point I would like to stress, in making examinations of this sort, is that one may find a contamination which is considered possibly vaginal, in the form of pus cells. Do not assume that that is a vaginal contamination. Be sure that it is not a prostatic contamination, which will be responsible in an equal measure for the sterility. A prostatic smear or condom specimen should be insisted upon from the male as well as the Rubin test on the female.

*Dr. H. A. Day, Orlando:*

I think Doctor Hoffmann has read a very important paper. This is something that concerns the lives of all of our people and all of our patients, something heretofore not having been looked into as carefully as Doctor Hoffmann has done. He has given us the high spots of what has been going on in the research world in the last few years. They are great advances and we may thank Doctor Hoffmann for enumerating them. Further

elaboration on the details of these different tests and examinations is useless at this time. I just want to tell Doctor Hoffmann that I appreciate being able to be here and discuss his paper, and I think that we all got a great deal of good out of it.

*Dr. C. D. Hoffmann, Orlando (Concluding):*

I want to thank these gentlemen for discussing this paper. They probably know as much or more than I do about this subject. I feel that all of this work is still in its embryonic stage and that there is still considerably more to be known on this subject. I feel that it does have a definite place because, personally, I know that there are as many women who want children and couples who want them as there are those who don't want them.

The Rubin test is frequently run under water but that is not always a safe procedure. Another point I would like to mention is that it is unsafe to carry a tube up to 215 or 220 mm. of pressure, because tubes have ruptured at 220 mm. So it is with a great deal of precaution and care that insufflation should be carried higher than 200 mm.

## LUPUS ERYTHEMATOSUS

LAUREN MCC. SOMPAYRAC, M. D.,  
Jacksonville.

The justification for considering lupus erythematosus as a subject of general interest to the Florida Medical Association is the apparent increase in incidence of this disease. Observations in Philadelphia by Ludy and Corson<sup>1</sup> lead to the conclusion that a virtual epidemic of this malady is present. This increased incidence has also been noted by Bechet<sup>2</sup> of New York and Kirby-Smith<sup>3</sup> of Jacksonville. It is generally conceded that sunlight has a definite role in the etiology of this disease, hence the subject becomes of peculiar interest to the physician of "The Land of Sunshine."

### HISTORY

First described by Bielt<sup>4</sup> under the title "Erytheme Centrifuge," it was Hebra<sup>5</sup> who in 1845 gave it the name *Seborrhea Congestiva*. Its present title was given by Cazenave<sup>6</sup> in 1850.

<sup>1</sup>Read before the Sixty-fifth Annual Meeting of the Florida Medical Association, held in Miami, May 9, 10, and 11, 1938.

### DESCRIPTION

This erythematous, scaly, patchy disease of the skin is usually chronic, sometimes acute. It frequently leaves superficial atrophy and scar formation, is capricious in its course and not infrequently terminates fatally in certain of its forms. For practical purposes this disease is divided into the common discoid variety and the diffuse or disseminated variety.

The discoid variety is usually chronic, lasting in cases for a quarter of a century or longer and throughout that time not interfering with the general health. There may be short periods of rapid advancement and then the disease remains stationary. The usual sites are the face with its frequent bat-wing distribution, scalp and ears but may occur on any part of the body. The patches are neither spontaneously painful nor sensitive to pressure. Superficial scratching, however, causes decided discomfort, and more frequently pain. The mucous membranes may become involved. Chronicity, telangiectasis, erythema and scarring are characteristic of this variety. It has well earned Stelwagon's<sup>7</sup> descriptive phrase, "destroyer of good looks."

Lupus erythematosus disseminatus may occur as a primary acute systemic disorder accompanied by grave constitutional symptoms; or similar acute manifestations may develop during the course of the discoid variety, not infrequently following sunburn. In the primary acute form the face is edematous and swollen and resembles erysipelas in many respects. On the hands the lesions may be erythematous papular or purpuric. On other portions of the body the eruption is multiform. Bullae, vesicles, scaling patches, crusted areas, hemorrhagic lesions and generalized telangiectasis have all been described. Itching and burning sensations may be mild or marked especially on the face, hands and feet. General symptoms include fever of septic nature, arthritic pains involving the muscles and bones as well as joints, gastrointestinal disturbance, anorexia, nausea, vomiting, diarrhea, loss of weight and prostration. The usual blood picture is a relative leukopenia with increase in lymphocytes. This is of value as a guide in treatment of the disease.<sup>8</sup> Thrombopenia has been reported. Albuminuria and other pathological findings indicate kidney invasion.

Urinalysis, particularly in cases of acute lupus erythematosus disseminatus, showed a high incidence of hematoporphyrin. This has led to a belief that the light factor and presence of photosensitizing agent in the blood might account for the cutaneous lesions.<sup>1</sup> Microscopic findings are marked hyperkeratosis with follicular plugging, epidermal atrophy; non-specific inflammatory reaction of the corium largely perivascular, and partial destruction of the glands and follicles.

### ETIOLOGY

Lupus erythematosus is more common in women than in men and usually appears first in the third decade of life. It may follow seborrheic dermatitis, acne, variola, erysipelas, undue exposure to sunlight and traumatism from any cause. By an increasing number of writers the disease is considered a chronic inflammation due to a toxic infection, the exact nature of which is not known. The relationship to tuberculosis is a much disputed question and though it has none of the essential characteristics of local tuberculosis, it occurs not infrequently as a dermatosis of the tuberculous. Recent observations suggest a focal infection as the probable source of intoxication in some instances. Barber<sup>9</sup> (England) recorded the case of a patient in whom he regarded a streptococcal infection in the tonsils as important etiologically.

In a very recent article<sup>1</sup> the possible role of the heavy metals was emphasized and the summary of the possible factors necessary for the production of lupus erythematosus was given as follows:

1. A focus of infection which affords the necessary antigen.
2. A toxic metal such as lead which acts as a catalyst.
3. Sunlight which affords the ultraviolet ray and thus acts as a spark to the bomb.

In a recent discussion Bechet<sup>2</sup> makes the following statement: "Many of these patients state that the disease apparently began after the subsidence of a severe blistering sunburn. I have long been convinced that actinic exposure is a factor in the production of lupus erythematosus, and its present increased incidence may well be accounted for by the present tremendous popularity of excessive exposure of the skin to the sun or ultraviolet radiation. I have observed two patients who



suffered from acute lupus erythematosus after serious burns from over-exposure to ultraviolet ray lamps in their own homes."

The factor of sunshine in the etiology of this disease is of direct concern to those of us in this state. Happier our lot if we could duplicate the results of Franck<sup>10</sup> who effected a cure by the use of gold salts and ultraviolet light. However, the damaging effect of ultraviolet light is generally agreed upon. Our abundant sunshine with the increasing popularity of sun-bathing may well influence the incidence in this locality. And if we are heedful of the observation that the incidence is higher in nervous, energetic, overactive individuals, many of whom are present in our tourist population, we find adequate explanation of the possibility of an increased incidence of the disease. However, there is no occasion for alarm if we will keep it in mind and regard with suspicion the dermatitis that fails to clear up on appropriate treatment.

#### DIFFERENTIAL DIAGNOSIS

The early stage may be confused with urticaria, erythema multiforme, or even drug eruption. Often a case seems to develop on a seborrheic dermatitis. The character of the scale, the follicular plugging, the more definite erythema and the atrophy help to distinguish lupus erythematosus from the more superficial seborrheic dermatitis.

Lupus vulgaris in Florida, for all practical purposes, can be dismissed. French and Lefholz<sup>11</sup> observed that cutaneous manifestations of tuberculosis become less frequent as one approaches the equator and expressed the belief that no proven case of lupus vulgaris originating in the State of Florida has been reported. Rarely do we have the history of moisture or excessive itching found in eczema and the acuteness of even chronic eczema as compared with lupus erythematosus will suffice to distinguish the two diseases. Psoriasis is characterized by more lustrous and more readily exfoliating scales. Its patches are uniformly well covered with scales and are of equal flatness in all parts; while those of lupus erythematosus are irregularly squamous, the scales being often clustered at the orifices of the ducts of the sebaceous glands while the rim of the patch is elevated and the center depressed. Removal of the scales of lupus erythematosus usually causes the patient to

wince with pain. In acne rosacea there are marked telangiectases and papulopustules or nodules which are not found in erythematosus lupus.

#### TREATMENT

A thorough physical examination should be made with especial emphasis on tuberculous infection, and possible foci of infection. Much depends upon the variety and stage of the disease. In the acute disseminating variety, rest, cod liver oil, sedation and diet play the most important role. Heavy metals, especially gold, have little if any place in this variety and it is generally agreed among dermatologists that gold, if given at all, should be in literally homeopathic doses. In the discoid variety the physical examination again may reveal the toxic focus. Removal of such foci of infection as teeth or tonsils followed by autogenous vaccine therapy has resulted in improvement or complete eradication of the lesion. Of the drugs recommended for oral administration, quinine merits probably the most consideration. However, results from this method of treatment are not highly satisfactory.

The French tendency of recent years to prefer bismuth to gold<sup>12</sup> has not been generally accepted but is constantly gaining ground everywhere. Wise and Sulzberger<sup>13</sup> stated that gold salts may be used in the treatment of lupus erythematosus, provided bismuth preparations have failed but in their opinion should not be used as a first measure. Despite its toxicity and occasional disastrous results of its use, gold has maintained its position as the treatment of choice in the chronic discoid form of lupus erythematosus. An even better outlook from the use of gold therapy has recently taken form. Obermayer and Becker<sup>14</sup> have recently reported favorable results by the use of ammonium succinimido-aurate. They conclude that the complex salts of the imidoauric acids in the form of the ammonium or sodium salt, represent gold compounds of low toxicity suitable for intravenous therapy where gold treatment is indicated; that their toxicity is much lower than that of sodium gold thiosulfate and when used in lupus erythematosus they show a therapeutic effect similar to, but perhaps slower than, that of sodium gold thiosulfate.

These investigators recommend prolonged rational treatment in the form of alternating



intravenous courses of gold and intramuscular bismuth injections with interpolated rest periods, during which time the patient is given quinine sulfate by mouth. "Rational" treatment as opposed to symptomatic treatment is certainly more worthy, especially in view of the frequent tendency for recurrence.

It follows from what has been said under causation that protection of the skin is of prime importance. Particularly should the patient be cautioned about sun exposure. Soothing lotion on the acute lesions, sulfur when the seborrheic element is marked and sometimes in chronic discoid patches local destructive agents may be used. Probably the most satisfactory of these is carbon dioxide snow. X-ray is rarely of value, and a review of the literature for the last twenty-five years showed that x-ray has been used less and less in treatment of the disease.<sup>14</sup>

#### RELAPSE

Even in the face of apparently adequate treatment relapse is encountered. Stokes and Callaway<sup>15</sup> recently reported a series of thirty-one cases which they followed up a sufficiently long time to make the conclusion that in twenty-two cases there were relapses. Each patient had from one to four relapses and of forty relapses eighty-five per cent occurred during the spring or summer, which to them suggested the influence of sunlight. Forty-two per cent were definitely related to exposure to sunlight. Twenty-three of these patients gave a history of previous over-susceptibility to sunburn. Nervous stress and strain undoubtedly played a part in causing relapses in seven patients of their series. One of their relapses occurred after a fractional dose of roentgen ray.

#### SUMMARY

Lupus erythematosus is apparently on the increase. The discoid variety is usually chronic and has been termed "the destroyer of good looks." The diffuse type is frequently acute with accompanying grave constitutional symptoms.

Possible etiological factors include: foci of infection, toxic metal, sunlight and trauma from other causes.

The role played by sunlight is emphasized with particular reference to Florida.

A brief differential diagnosis is included.

Recent trends in treatment indicate gold the drug of choice with bismuth gaining favor. Ammonium succinimido-aurate gives promise of safer gold therapy.

Some factors influencing relapse are discussed.

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## DISCUSSION

*Dr. J. L. Kirby-Smith, Jacksonville:*

Doctor Sompayrac today has given us a very interesting account of one of a chronic disfiguring dermatosis. His lantern slides well illustrate the situation.

At the beginning of my work in the study of dermatology, most authorities considered lupus erythematosus in the group of tuberculids. Only in comparatively recent years has the subject of focus infection of various parts of the body been incriminated. Still many cases of lupus erythematosus can be attributed to tuberculosis of other parts of the body.

A few years ago at our annual meeting in Ocala I had occasion to discuss a paper by C. A. Andrews of Tampa, "Florida Sores." Resentment was expressed at the implication that we had any distinct skin disease peculiar to this State. Doctor Sompayrac's emphasis of sunlight in Florida as a factor in the cause of lupus erythematosus should require some consideration. As a matter of fact, all of you know that we have plenty of this and it is our best "stock-in-trade." Unquestionably there is an increase in the incidence of lupus erythematosus in Florida. It may be that the disease is better recognized by the profession. However, our people and particularly the visitors do unduly expose their faces to the bright sunshine. All of us know that certain types of skin, particularly blonds, are photosensitive. With an existing circulatory disturbance of the soft part of the face, and this possibly from focal infection, it can be readily understood how excessive sun exposure in certain individuals may produce this chronic, inflammatory, scaly skin affection of the face.

This is my impression and I think corresponds to the statements of the essayist. Most surely it is not proposed that all people stop sun baths. It would not be any more appropriate for us to advocate this, than it was for one of our prominent pediatricists, at a previous meeting, to caution against the use of quinine because a few cases of blindness may have been reported from the use of the medicine.

*Dr. Elmo D. French, Miami:*

I do not believe that the essayist sufficiently clarified his point of view as to the role sunlight plays in the disease we know as lupus erythematosus.

In my observation, lupus erythematosus is not unduly prevalent, nor is it of increased incidence at this time in south Florida, where during the winter months we have more actual hours of sunshine than in any section of the continental United States. It cannot be denied, however, that the effect of ultraviolet light, or of sunlight, upon lupus erythematosus is to increase the manifestations of the disease. This property of photosensitivity, lupus erythematosus shares with many other disease entities.

Pellagra is more markedly sensitive to solar radiation than lupus erythematosus. A limited amount of ultraviolet radiation will aggravate furunculosis. Acne is aggravated by sunlight especially at the seaside. Impetigo occurs more profusely in exposed areas. Herpes simplex, known to be caused by a virus, recurs almost regularly a few hours after an intense sunburn of the involved region.

Not so obvious but no less real as factors baleful in their effects on lupus erythematosus, which like sunlight should be classified as predisposing causes, are: cold, menstruation, pregnancy, menopause, or anything that leads to regional congestion.

As to the etiology of lupus erythematosus, I think we as yet must adopt an attitude of more or less eclecticism. Too many objections have been offered to all theories so far advanced and they lack final proof.

The diagnosis of the disease is, in typical cases with an atrophic depressed center and infiltrated keratotic border, easy. In the very early cases, where erythema

is the dominating symptom and the other features very slight, the diagnosis is at times difficult. The histopathology is not conclusive.

In the treatment of the disease, I think we should remember the dictum of Petges: "An experienced physician approaches lupus erythematosus, as he approaches eczema; cautiously." Local treatment is not confined to the proper use of carbon dioxide snow nor general treatment to the parenteral injection of gold, or arsenic, or bismuth. In advanced cases, cod liver oil and the iodides are of value and in the chronic forms, adrenalin calcium salts and vitamins. In acute cases ergot, aconite and quinine have proved of benefit.

In closing I wish to repeat for the sake of emphasis: sunlight or ultraviolet light never produce lupus erythematosus and in no sense whatever can we believe it has anything to do with any alleged increase or decrease in the incidence of the disease.

## COMMON FRACTURES ABOUT THE WRIST

EUGENE L. JEWETT, M. D.,  
Orlando.

Fractures about the wrist are usually caused by a fall on the outstretched arm with the wrist extended. Other forces of indirect violence and also direct violence, such as having the wrist hit with an automobile crank may produce injuries in this region. The volar radial carpal ligament attaches about one-half inch proximal to the articular surface of the radius and is the stronger of the two capsular ligaments. The weaker one (the dorsal radial carpal ligament) attaches about one-fourth inch proximal to the articular end of the radius and with the radial and ulna collateral ligaments complete the strong fibrous covering of the joint.

Indirect violence from a fall usually hyperextends the wrist joint and causes the so-called Colles' or suprazygoid fracture. This fracture produces the typical silver-fork deformity, of which you are all so well aware. The radius is usually fractured from one-half inch to three-quarters of an inch proximal to the joint space with often a comminution that extends into the articular surface of the radius. The radial fragments usually become impacted in the dorsally displaced and oblique position with or without the ulna being involved. When the ulna is injured there usually is involvement of the distal radial ulnar articulation and the articular disc which separates the ulna from the carpal bones. Both the radial and ulnar collateral ligaments may be

Read before the Florida Midland Medical Society, Orlando, April 28, 1938.



partially torn, although usually they remain intact along with the dorsal and volar radial carpal ligaments. Often several of the tendon sheaths on either one or both surfaces of the wrist joint are traumatized, although the tendons themselves are rarely severed. In this typical Colles' fracture the distal articular surface of the radius points from ten to thirty degrees backward as one looks at the lateral view. Normally this angle should be about five or ten degrees anterior to a ninety degree vertical axis.

The reversed suprastyloid or Colles' fracture is called a Smith's fracture, and is a rather rare occurrence. It shows up as a garden-spade deformity with the convexity of the hump being on the anterior in place of the posterior aspect of the wrist. A Barton's fracture is one where only the posterior lip of the radius is fractured and may give clinically the same deformity as the Colles'. The reversed Barton's has a fracture of the anterior articular lip, and is a rare clinical finding.

The diagnosis of wrist injuries can usually be fairly well undertaken without the use of the x-ray, but the latter should always be employed as soon as possible. A complete posterior luxation of the entire carpus may simulate absolutely a Colles' fracture, and even a dislocation of one of the carpal bones may throw us off. Generally the anterior-posterior and lateral views of the wrist are all that are necessary, but at times we need the posterior-anterior as well.

The symptoms of these wrist injuries depend a great deal on the length of time post-trauma, and are therefore dependent not only upon the bony damage but also on the soft tissue trauma and swelling. The neural and circulatory impairment are therefore caused not solely by the original injury, but in many cases are due to the resulting tumefaction and pressure.

The need for immediate reduction of these fractures is all important. When we consider that there are twenty-eight tendons going over the wrist joint, not to mention the nerves and blood vessels, we get a vivid picture of what malposition and vicious pressure swelling will do. In the first few hours posttrauma, the ordinary fractured wrist usually can be easily disimpacted and reduced. After this initial

'golden period,' however, the extreme swelling and induration of the part, combined with the spasm of the muscles, makes the reduction a different proposition.

In the adult patient with a wrist fracture, local novocain injection is the method of choice, although we are using evipal more and more. The novocain lasts longer, however, and permits checkup x-rays and re-reduction if indicated. A pre-reduction sedative may help but if the patient is extremely nervous or highstrung, of course, novocain should not be used.

We must always remember that the injection of novocain is a surgical procedure which necessitates the same aseptic precautions and careful technique as any other operative undertaking. I generally use a one per cent solution of novocain without epinephrin added. Many men use the mixed solution of novocain and epinephrin, but I do not see any great need of the latter. Of course, in cases of marked shock the adrenalin would tend to combat that, but if there is such an extreme degree of shock any reduction at all would be contraindicated. The needle had better be an eighteen gauge, which is the regular Wassermann type, as the smaller hypodermic needles are too easily bent or broken on the bony spicules that are encountered. Always we must get a good flow of blood into the syringe, which tells us that we are well in the hematoma. The novocain should then be injected very slowly with a one or two minutes' rest after the first cubic centimeter is given, so as to be sure no untoward reaction will come from the novocain. Certain people become faint and show a more or less minor degree of shock from this anesthetic, especially when it is injected directly into the blood stream, as happens in such a fracture case. Usually one injection of eight to fifteen cubic centimeters is all that is needed to take care of even the worst fractures of the radius, and about half this amount for the ulna. Where only the tip of the ulna styloid is fractured, often no novocain is needed here at all. Following the injection of the novocain, dry sterile gauze is placed over each puncture hole and the part gently massaged in order to dissipate any swelling that is present and to hasten the distribution of the drug.



When the part is completely anesthetized, which usually occurs in a few minutes, the fragments are disimpacted and reduced. Usually gentle and persistent traction on the hand with fixed countertraction instituted by either a padded sling on the arm with the elbow flexed or with an assistant holding the arm is all that is needed. The deformity is best increased first and then the reduction carried out. Strong pressure over one's knee is an excellent method of exerting the force. The hand-shake grip is nowhere near as effective as grasping the patient's wrist from the side with one hand below and one above the fracture site. If we are fortunate enough to do this with fluoroscopic control we can check up on the anteroposterior and lateral positions immediately. Otherwise, we have either to trust to our judgment or take checkup x-rays before putting on the immobilizing device. Again, let me stress that absolute anesthesia is necessary for complete muscular relaxation.

When the questions of the best position for immobilizing the wrist and the method of retaining this position come up, we find well justified differences of opinion. In the ordinary, not too severe, case, the wrist may be put up in the midposition, especially if the fracture has been adequately reduced and re-impacted in the corrected alignment. However, when one sees recurrence after recurrence from such a system one more and more advises the Cotton-Loder position in most cases. This position is the one in which the wrist is flexed and ulna deviated to a greater or less degree. In the oblique fractures where there is a great danger of a recurrence this position should be very pronounced, whereas in the ordinary case only a moderate amount of flexion and ulnar deviation is necessary. Of course, where this method is used there is just so much more danger of circulatory disturbance and neural damage which adds to the ever vigilant responsibility of the surgeon in charge. At the first sign of any of the four cardinal findings of a too tightly or wrongly applied device there must be a loosening of the bandage, a bivalving of the cast, or a modification of the position of immobilization. The four cardinal danger signals are, as you all know, swelling, numbness, coldness, or blueness of the fingers or thumb. The pa-

tient or responsible members of his family must be carefully instructed about this matter, and at the first appearance of any of these changes the doctor must be notified at once.

Generally I use anterior and posterior moulded plaster of paris splints, and find them satisfactory in the vast majority of cases. Every now and then, however, it is better to use a bivalved plaster cast. The splintage or cast should usually extend no farther on the palm of the hand than the transverse flexion creases, and on the dorsum just proximal to the knuckles. This allows for free use of the fingers, which should be encouraged from the very onset. In the usual case where the Cotton-Loder position is used, after ten days or so, the wrist is gently brought back to the midposition and new splints applied. The same is true for a cast. We are all getting away from the former universally used heavily padded, bulky, plaster of paris cast or splints. We are now using only one or two layers of stockinet or Canton flannel, and in many instances no padding whatsoever, although a little piece of felt over the bony prominences does seem to help in most cases. In putting on such a practically nonpadded cast or splints great care must be taken to mould the plaster exactly to the part encased or covered. The above immobilization is retained for from three to five weeks postreduction, depending upon the clinical and roentgenological findings. As long as the callus is soft and tender it needs external support and this is easily determined by examination and x-ray. If active motion of the fingers has been maintained constantly throughout the period of immobilization there will be much less need for physiotherapy later on. In many cases, however, some physiotherapy will be needed in order to hasten the return to good function. Each case should be followed until a final result is obtained, and everything possible done to get a satisfactory functional, anatomical and cosmetic result.

Several writers advocate an open reduction on every reversed suprazyloid or Smith's fracture, but others are just as positive that a closed reduction be tried first. My experience with a few that I have seen, is that the closed method should be by all means attempted first and usually is sufficient. The

Barton's fracture and the reversed Barton's fractures do not ordinarily present any difficulty in reduction or retention.

In the past two years I have reduced twenty-seven fractured wrists, most of them being done in our clinic on the fluoroscopic table, and with novocain as the anesthetic. There are five old, more or less malunited cases, of which on three I had to resort to open surgery. Two of these cases were about one month post-trauma, and even though marked malposition

had occurred I was able to obtain and maintain a closed reduction.

CASE I. This x-ray (Plate 2), shows the initial fracture of the right wrist at the time of accident. There is moderate posterior displacement of the distal fragment with obliquity of the articular surface, and the mistake was made here of assuming that the fracture needed no reduction. This accident happened in Mexico City where the patient, who was a 65-year old woman, obtained what was thought to be the best surgical attention. Her wrist was put up in cardboard splints and, on arrival in this country, about four weeks later on, we find the picture which is shown in Plate 2. The malposition is much more marked, and there is no evidence of callus. The patient was anesthetized under



CASE 1, PLATE 1

A. P. and lateral views of the right wrist at time of accident. Wrongly interpreted as needing no reduction. Not a true lateral.



CASE 1, PLATE 3

A. P. and lateral views postreduction with anterior and posterior splints in position.



CASE 1, PLATE 2

A. P. and lateral views of both wrists four weeks posttrauma. Silver-fork deformity more marked than in the beginning and non-union.



CASE 1, PLATE 4

A. P. and lateral views four weeks postreduction, splints removed.



CASE 2, PLATE 2

A. P. and lateral views showing increasing posterior and lateral displacement of the radial head.

evipal and reduction was obtained fairly easily with the corrected position shown in Plate 3. Plate 4 shows the wrist about one month postreduction, and the position and callus formation are entirely adequate. The patient has at present a symptomless, practically normal, wrist.

CASE II. This is a case of fracture of the right wrist in a man of about forty-five years of age. The accompanying x-ray reproductions show the increasing deformity over a period of one month, during which time several unsuccessful attempts were made to reduce the fracture. The first posttraumatic plate shows good position of the fragments. I saw the patient one month after the accident, and even though he had what seemed to be a firm malunion I attempted a closed reduction under general anesthesia. Using very strong traction by means of a fracture frame the fragments were finally disimpacted, the fracture reduced, and the wrist immobilized in anterior and posterior moulded plaster of paris splints with the wrist in marked Cotton-



CASE 2, PLATE 3

A. P. and lateral views showing the reduction and immobilization in plaster-of-paris splints.

Loder position. New splints were applied ten days postreduction with the wrist swung up into the midposition. All splints were removed four and one-half weeks after reduction, and the last plate shows the condition of the bones about five and one-half weeks postreduction. He has practically a normal wrist with only a slight limitation of dorsiflexion.

CASE III. A girl aged ten was seen one month post-trauma. Her wrist had a suprazyloid fracture about one inch proximal to the lower end, and there was malunion with marked dorsal angulation and posterior obliquity of the articular surface as is shown in Plate 1. An open correction was done through a two-inch vertical incision over the middle of the lower end of the radius. Plate 2 shows the condition ten days postoperative, and reveals a slight gaping of the anterior surface of the fragments. This was corrected under the fluoroscope and new splints applied, which brought the



CASE 2, PLATE 1

A. P. and lateral views which show relatively fair position of the fragments.





CASE 2, PLATE 4

A. P. and lateral views taken five weeks postreduction. Alignment good, callus ample.



CASE 3, PLATE 2

A. P. and lateral views of the right wrist ten days postoperative.

2 taken immediately after the operation shows a somewhat over-corrected position. In this case I made one inch lateral and medial incisions along the lower end of the ulna and also over the lower end of the radius. The radius was entirely denuded of periosteum around its lower end and a wedging osteotomy was taken out from side to side. About one-half inch of the ulna styloid was removed, so as to eliminate the radial thrust of the hand. This boy has not carried out the exercise instructions, but he is obtaining a very good wrist notwithstanding. He has a moderate degree of anterior displacement of the wrist, but functionally and anatomically he will improve as time goes on.

CASE V. This is a case of marked mal-united radial fracture, which is still under treatment and the end result is not yet determined. The patient has had two operations and is going to get a useful functioning wrist, but as he is steadily improving his final disability is still uncertain.



CASE 3, PLATE 1

A. P. and lateral views of the right wrist one month posttrauma.

adjacent fragmented ends together. Plate 3 shows the condition of the wrist about ten weeks postoperative. There is some callus formation on the dorsum of the radius, which is rapidly melting away. She was seen two weeks ago and had practically perfect use of her wrist at that time.

CASE IV. A twenty-year old colored boy had what was called a mushrooming fracture in 1932. X-rays at the hospital had been destroyed, and there was nothing on his history except mushrooming fracture of the radius. He came to me complaining of pain and weakness when he used the wrist. Clinically he had a typical silver-fork deformity with dorsal over-riding and obliquity as clearly shown in Plate 1. This is the type of wrist that becomes weaker and weaker and ends up with marked disability and pain. He had also a pronounced radial thrust to the wrist, and the tip of the ulnar styloid was fractured but was symptomless. Plate



CASE 3, PLATE 3

A. P. and lateral views of the right wrist ten weeks postoperative.



CASE 4, PLATE 1

A. P. and lateral views taken five years posttrauma.

## SUMMARY

A short discussion has been given about some of the suprazyloid fractures of the wrist. I wish to emphasize again the absolute necessity for: accurate early diagnosis; immediate accurate reduction and retention of the fracture with complete local anesthesia and muscular relaxation; careful, ever vigilant follow-up with adequate checkup x-rays and continuous use of the fingers; as complete a restoration to normalcy as possible, not only with regard to anatomical position but also function. A fractured wrist is like a sick

appendix; it can be the easiest to attend to or it can offer the greatest of obstacles to even the most experienced surgeon.

*11 Lucerne Circle.*

ALUM IN THE TREATMENT OF  
ACUTE HEMORRHAGE

J. A. MEASE, JR., M. D.  
Dunedin

Eighty-nine per cent of acute gastric hemorrhages are due to gastric or duodenal ulcers; 4.5 per cent to cirrhosis of the liver; 1.3 per cent to carcinoma; and 5.2 per cent to other causes, among which may be mentioned digestive anaphylaxis, stricture of the duodenum, gastric purpura, hemophilia, esophageal varices, polyposis, alcoholic debauch, leiomyosarcoma, and gastroduodenitis. Some causes which cannot be determined by x-ray or clinical findings are usually classified as luetic.

## SYMPTOMS AND DIAGNOSIS

The degree of hemorrhage, whether small and repeated or massive, can usually be determined by the symptoms. In a small hemorrhage there is frequently epigastric pain with tarry stools and signs of secondary anemia. In massive hemorrhage the symptoms are thirst, tremor, profuse perspiration, palpitation, tinnitus, pallor, coldness of the extremities, and the desire to defecate. The stools may be frequent, copious, tarry and contain recognizable blood. Temporary blindness is rare. Hematemesis occurs and is caused by the rapid distention of the stomach.

Most gastric hemorrhages are massive and recurrent. The history, physical, laboratory and roentgenological examinations will usually determine the specific cause. Only after a severe hemorrhage with rupture of a blood vessel is death likely to occur. Patients over the age of 40 with sclerosed blood vessels are most prone to this condition.

## TREATMENT

Inasmuch as ulcer is the most frequent cause of hemorrhage it is usually safe to assume it is the condition to treat in acute massive hemorrhage from the stomach, provided there is no striking history, symptoms or find-



CASE 4, PLATE 2

A. P. and lateral views taken immediately postoperative.

Read before the Florida Midland Medical Society, Orlando, April 28, 1938.

ings to make an immediate diagnosis of some other condition. The cause of the hemorrhage will determine whether the treatment should be medical or surgical. Most men agree that surgery in acute hemorrhage is contraindicated unless the bleeding is from a ruptured sclerotic vessel and even then the mortality rate is high. The elective time for surgery is during a quiescent period.

The object of any treatment is to control the hemorrhage by clotting. To facilitate this there are several factors to be taken into consideration. The stomach should be empty and contracted with the mucous membrane lying in deep folds. Peristalsis should be reduced to a minimum. It is beneficial to increase the coagulability of the blood to above normal. Vomiting and increasing the blood pressure should be avoided. The patient should be kept warm and the respiration and heart action slowed.

To accomplish these results morphine and strychnine are given hypodermically, and food is withheld for 24 or 48 hours. Blood transfusion in small, repeated amounts is ideal to keep up the blood volume, but when not available, saline is given either intravenously or by clysis as it does not affect the coagulability of the blood. Blood given intramuscularly acts as a good coagulant itself. When gastric lavage is used to empty the stomach, drugs may be introduced through the tube. However, coagulents applied locally have been reported to produce shock. The available coagulants are caphalen, thromboplastin, coagulin, blood serum, whole blood, sodium citrate, and calcium. The newer specific treatments, such as histidine, foreign protein, mercurial derivatives, etc., are recognized as having a limited field.

In the following cases of gastric hemorrhage I have used potassium alum in conjunction with the usual medical treatment. In searching the available literature I have found no reports of the use of alum by mouth except in one case of chronic poisoning administered by food. The symptoms in this man were severe pain after meals, with nausea lasting most of the time and loss of weight. White and Smith say regarding alum administration: "In large doses it is emetic acting directly on the stomach and in larger doses still,

it is irritant and purgative. Most, if not all, is passed by the feces; probably in medicinal doses it has no more remote effect on the tissues. Nervous system: Given to animals in large doses it produces paresis, loss of sensation, forced movements, drowsiness and death from respiratory paralysis."

During the past year I have had several patients who were taking one rounded teaspoonful of alum mixed with brown sugar once daily every fifth day for reducing arterial hypertension with no apparent untoward effect. Also, in one of the A. M. A. Journals in 1937, under "Queries and Answers" I found the following:

#### EFFECTS OF ALUM IN DIABETES

A woman, aged 52, had markedly severe diabetes some years ago and with diet now has only infrequent symptoms. She can make herself sugar free if and when she does adhere to a more or less restricted diet. Like all patients with diabetes, she likes to go on a spree once in a while. To get to the point in question, however, she tells me that for a number of years she has been able without dieting much, if any, after one of these sprees to cause her urine to test sugar free and to feel much better by taking a solution of ordinary alum; i. e., 4 teaspoonfuls of water and one teaspoonful of powdered alum, taking one teaspoonful in half a glass of milk from three to four times daily. This, she says, will make her urine "clear" in about three days to one week, being "red" at the start. Can you tell me the pharmacology and possibly the physiologic reason for this? I have not tested her urine before and after this medication, as she is a thoroughly reliable person. Needless to say, blood sugar tests are done infrequently here and I have not done them. I thought that possibly the alum might have an action on the kidneys to raise the threshold for sugar. However, it seems to me that if that were true, her blood sugar would rise and she would feel worse instead of better.

Answer:—We have been unable to find any reference in the scientific literature to the use of alum in the treatment of diabetes. If, as suggested, the alum raises the kidney threshold for sugar, simultaneous blood and urine sugar determinations at that time would reveal this effect.

This patient can render herself sugar-free after a spree by following a restricted diet. A more probable explanation of the effect of alum may therefore be that this strongly astringent material interferes with the absorption of foodstuffs from the gastro-intestinal tract and is therefore equivalent to a dietary restriction.

The following cases are the ones I have personally seen and treated:

#### CASE REPORTS

CASE 1. W. J. F., a white male, aged 40, salesman, had been on an alcoholic debauch of one week, during which time he had eaten very little food. Without preliminary symptoms, he suddenly had a massive gastric hemorrhage and vomited blood. Six months previously he had had a similar hemorrhage after a drinking spree and was x-rayed. This x-ray examination was negative for pathology so the alcohol was probably the cause. It took him about 4 weeks to recover from the first attack so that he could return to work. In the second attack he had typical findings of gastric hemorrhage and from the history and his condition I judged the second attack to be from the same



cause. He was put on a modified Sippy diet following a 24-hour period of starvation. In addition he was given 5 grains of alum three times a day. The alum was started soon after he had the hemorrhage. The bleeding stopped immediately and in one week's time he was back on the job. This was 5 years ago. When I last heard from the patient, 2 years ago, he had had no recurrence and was carrying a box of 5 grain alum capsules with him "just in case."

CASE 2. J. D., a white male, automobile dealer, aged 33, was admitted to the hospital with a bleeding duodenal ulcer. He had been drinking, but moderately. The outstanding symptom was pain in the abdomen. He did not manifest any symptoms of shock and did not vomit although his stools were tarry. He had previously been x-rayed and a diagnosis of ulcer made. His history revealed that he had had a previous slight hemorrhage but no pain and was following a dietary and medical ulcer regime. He was given morphine and saline intravenously. Food and liquids were withheld for 48 hours, but 5 grains of alum were immediately given and continued three times a day for 5 days at which time he left the hospital. He has had no recurrence of the bleeding during the intervening 14 months.

CASE 3. H. O., a white male, aged 30, foreman of welding room, entered the hospital complaining of vomiting free and clotted blood. He had begun to vomit blood in the morning but had continued to work thinking it was probably something he had eaten. In the afternoon he became so weak that he had to quit work and seek medical advice.

There were no previous illnesses, symptoms or physical findings other than that he was pale and weak. His stomach was washed out and 5 grains of alum given at once. Also, he received intravenous saline and morphine. The alum was given in 5 grain doses three times a day. Nothing was given by mouth for 24 hours. After the alum was given the vomiting stopped. He was put on a modified Sippy diet after 24 hours' starvation and made a rapid recovery. His stools were tarry for three days. He was discharged from the hospital in one week and was back at work the next week. His Kahn test was negative and a later gastro-intestinal series showed no pathology in the stomach. He has continued well since then and now eats anything that he wants.

CASE 4. R. E. M., a white male, salesman, 42 years old, had been under treatment for gastric hyperacidity for three years. An x-ray one year previous to his hospital admission showed no ulcer. Suddenly he developed a gastric hemorrhage but did not vomit. He had all of the symptoms of hemorrhage and was sent to the hospital. He continued to bleed for three days, until finally blood transfusions, blood intramuscularly, morphine, etc., stopped the bleeding. He was not given alum. After two weeks in the hospital he was sent home and apparently made an uneventful recovery although he was kept on a strict diet. An x-ray six months later showed a duodenal ulcer that had perforated into the pancreas.

Almost one year from the first hemorrhage he developed another hemorrhage from the ulcer. Again he was hospitalized, given transfusions, saline, morphine, etc., but continued to bleed for five days at which time alum was begun by mouth and the bleeding stopped. He was given a Sippy diet and discharged from the hospital in three weeks. However, two weeks after his discharge he began to have severe pains in the abdomen which could not be controlled by alkalies or food, so surgery was resorted to. A subtotal gastrectomy was done; the ulcer perforating into the pancreas was confirmed. He is still in the hospital, but is recovering rapidly and should be home in a few days. This is one case where alum was not administered until after the ulcer perforated. It is problematical whether alum administered during the first hemorrhage would have prevented the second.

CASE 5. J. Z., a white male, manufacturer, aged 38 had been on ulcer diet and treatment for duodenal ulcer for four years. He had had a gastric hemorrhage before the treatment was begun. The second hemorrhage occurred in January of this year. He was brought to the hospital and the usual hemorrhage treatment was begun, including transfusion and five grains of alum by mouth. He did not vomit blood, so his stomach was not washed out. The bleeding immediately stopped, although he passed tarry stools for two or three days. He made a rapid recovery and although he could have been discharged in two weeks he stayed four weeks and then went back to work. An x-ray showed the ulcer had much improved since the former pictures were taken, one year previously. Another x-ray will be taken in two months and it will be interesting to see the results as he is taking 15 grains of alum every fifth day.

#### CONCLUSION

I have tried briefly to outline the causes, symptoms, diagnosis and treatment of gastric hemorrhage. The treatment of gastric hemorrhage to my mind is far from satisfactory, especially in the ulcer cases. Although it is true that most hemorrhages from the stomach are controlled, some people do bleed to death, and the period of disability, inconvenience and dietary restrictions which these people are compelled to undergo are certainly a stumbling block to their usefulness and general health. It may be that alum or some other type of astringent drug could be used to advantage in our armamentarium of treatment.

*Virginia Avenue.*

#### SEND IT IN

If you have a bit of news,  
Send it in;  
Or a joke that will amuse,  
Send it in;  
A story that is true,  
An incident that is new,  
We want to hear from you —  
Send it in.  
Never mind about the style,  
If the news is worth the while,  
It may help or bring a smile.  
Send it in.

— C. G. H. in "Sparks."

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continue your membership in the Association, your dues must be paid by the end of December this year. Why not save the secretary of your society unnecessary work and pay your dues immediately. In order to insure your county medical society its full representation in the House of Delegates, attend to this matter of paying 1939 dues at once.

The first meeting of the House of Delegates will be held at 9 a. m., Monday, May 1, at the Princess Issena Hotel, Daytona Beach. All delegates from county medical societies are urged to take notice of the time and date of this first meeting. A great many important questions are to be taken up at this first meeting, in addition to the reading of committee reports. Every delegate is urged to be present on time, so that the business coming before the House of Delegates may be taken care of before the noon hour. Echoes from the last meeting are very favorable to having the House of Delegates meeting on Monday forenoon. This gives more time for deliberation and gives the delegates more leisure during the convention for other meetings.

## THE HOUSE OF DELEGATES AND YOU

Your Association reached its membership peak last year. There were 1,293 members in the Association for the calendar year 1938, the largest representation your Association has enjoyed since its organization. The names and addresses of those who held membership last year will be found in the new Medical Directory, mailed to all members last month.

Your representation at the meeting of the House of Delegates, to be held May 1 at Daytona Beach, will be in proportion to the number of members who have paid their 1939 dues prior to that occasion. Thirty days in advance of the annual meeting, secretaries of component medical societies are required to forward 1939 dues of their members to the secretary of the State Association. The representation in the House of Delegates of each society will be on the basis of one delegate for each twenty paid members or major fraction thereof. Paid members in this instance means members whose annual dues have been paid for the year 1939. You are urged to cooperate with the secretary of your county medical society and pay your state dues promptly. To

## INTENSIVE COURSE IN DISEASES OF THE CHEST

The Medical Postgraduate Course Committee is attempting to arrange a week's intensive work in Diseases of the Chest with particular reference to tuberculosis and differential diagnosis. If there are a sufficient number of applications for this course it is contemplated that at least three hours of lectures a day will be given by an instructor who will be brought down for this purpose. In addition to these lectures, demonstrations will be given in the administration of pneumothorax and the interpretation of x-ray films of the chest. At least five hours a day will be devoted to the diseases of the chest.

The registration for this special course, which will be held in connection with the Seventh Annual Graduate Short Course, June 19-24, at Daytona Beach, will be limited to 15, inasmuch as the committee feels the instructor could not handle a larger class and give the individual instruction consistent with such an intensive course. Any physician registering for the special course will be allowed to attend other lectures in connection with the Short Course, but only those doctors reg-



istered for the special course and paying an additional fee of \$5.00 will be permitted to take the intensive work.

It is the desire of the committee to offer further courses of this nature in future years, if the reception of this year's subject warrants it.

Registration should be made immediately through the chairman of the Medical Post-graduate Course Committee, Dr. T. Z. Cason, 2033 Riverside Avenue, Jacksonville.

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### JOURNAL SUMMARIZES WAGNER BILL ON NATIONAL HEALTH PROGRAM

"On Feb. 28 Senator Wagner of New York introduced in the Senate a bill for the carrying out of some of the phases of the National Health Program," *The Journal of the American Medical Association* for March 4 reports.

"In the proposed bill Senator Wagner offers a series of amendments to the Social Security Act calling for an expenditure of federal funds amounting to \$80,000,000 the first year with gradual increases over a ten-year period for the purpose of establishing, expanding and improving state programs for '(1) child and maternal care; (2) general public health services and investigations; (3) construction of needed hospitals and health centers; (4) general programs of medical care, and (5) insurance against the loss of wages during periods of temporary disability.' Senator Wagner said in an interview that it 'should be clearly understood that the bill does not establish a system of health insurance or require the states to do so.' Funds would be made available under this bill to 'those localities and states which are in the greatest need of the services,' the size of the grants being determined 'on a variable matching basis, depending on the relative financial resources of the several states as determined by the per capita income of their inhabitants.' It is not possible at this time to offer a complete analysis of the details of the proposed legislation. Obviously, it will be necessary for suitable committees of the Congress to give careful consideration to the proposals. While the sum announced—namely, \$80,000,000 annually—is not large as compared with an annual expenditure of \$850,-

000,000 ultimately proposed by the National Health Program, it represents nevertheless a considerable sum. Senators interested in an economy rather than a spending program have already announced opposition."

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### LIFE EXPECTANCY

Babies born in 1938 have a 62-year lease on life.

The total "life expectancy at birth" for the United States last year, according to computations based on certain estimated factors released recently by the United States Public Health Service, was 62 years. This figure compares with an expectancy of 60.26 in 1931 and 60.9 as estimated for 1937.

While still somewhat below the biblical promise of "three score and ten," the life expectancy now is almost twice as great as it was 100 years ago. For the 7 years since 1931 a gain in expectancy of 1.74 years is indicated, while a gain of 1.1 years is shown in 1938 over 1937.

The expectation of life at birth, it is explained, "is the average age at death of a hypothetical group of persons each of whom is subject to the same age specific mortality rates throughout his lifetime."

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### PHYSICIANS' ART EXHIBIT

The American Physicians' Art Association, composed of members in the United States, Canada, and Hawaii, will hold its second art exhibit in the City Art Museum of St. Louis, May 14-20, 1939, during the annual session of the American Medical Association. Art pieces will be accepted for this art show in the following classifications: oils, both portrait and landscape; water colors; sculpture; photographic art; etchings; ceramics; pastels; charcoal drawings; book-binding; wood carving; and metal work (jewelry). Practically all pieces sent in will be accepted. There will be over 60 valuable prize awards.

For details of membership in this Association and rules of the exhibit, write to Max Thorek, M. D., Sec'y, 850 Irving Park Blvd., Chicago, Ill.

## GRADUATE SHORT COURSE FACULTY

The Medical Postgraduate Course Committee announces with pride the faculty members for the Seventh Annual Graduate Short Course for Doctors to be held June 19-24, inclusive, in Daytona Beach. Three of the lecturers at last year's session will return for this year's course: Dr. R. J. Crossen, Assistant Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, for Gynecology; Dr. Maurice C. Pincoffs, Professor of Medicine, University of Maryland School of Medicine, Baltimore, for Medicine; and Dr. Beverley R. Tucker, Professor of Neuropsychiatry, Medical College of Virginia, Richmond. Another instructor well known to Florida physicians is Dr. Wilburt C. Davison of Duke University, who gave the course in Pediatrics in 1935 and will present it again this year. Newcomers to the program this year will be Dr. Raymond W. McNealy, Associate Professor of Surgery, Northwestern University Medical School, Chicago, and Dr. M. T. Pride, Professor of Obstetrics, University of Tennessee, Memphis, for the courses in Surgery and Obstetrics, respectively.

The exact times and subjects of the lectures will be found in a later issue of the *Journal*. Watch for the complete program.

## STATE NEWS ITEMS

The regular quarterly meeting of the Florida Society of Dermatology and Syphilology was held in Tampa, February 4. Dr. Chadbourne A. Andrews, chairman, provided a very interesting clinic, following which a round table discussion was held on the subject of the neurogenous factors in dermatology. A business meeting was held and the time of the next quarterly meeting was decided to be April 30 in Jacksonville. Members present were Drs. Elmo D. French, president; Wiley M. Sams and A. B. Litterer of Miami; Chadbourne A. Andrews and G. C. Bottari of Tampa; L. B. Mount of St. Petersburg; S. F. Ricker of Orlando; J. L. Kirby-Smith and Lauren M. Sompayrac, secretary, of Jacksonville. Rothwell Lefholz of Miami was a guest of the Society. The meeting was brought to a close with a luncheon program.

The members of the Duval County Medical Society interested in ophthalmology invited Dr. James W. White of New York to lecture on "Ocular Muscles." Dr. White's work on ocular myology is most outstanding. He is generally considered one of the best teachers in the country. The Jacksonville group issued invitations to all physicians in the state interested in ophthalmology, in order that they too might have the opportunity of hearing Doctor White. The first lecture was given Saturday evening, March 4, at 8 o'clock and the second, Sunday morning at 9.30, March 5. The lectures were held at the office of Dr. Shaler Richardson, where clinical cases were demonstrated. After the Saturday morning lecture the doctors enjoyed a luncheon at the Ponte Vedra Club, followed by golf. Saturday evening the group enjoyed a cocktail party at the home of Dr. Shaler Richardson on San Jose Boulevard. The Florida doctors registered for the lectures were as follows:

*Daytona Beach:* L. W. Glatzau. *Jacksonville:* Charles W. Boyd, W. Jerome Knauer, Reuben L. McDaniel, William S. Manning, Shaler Richardson, Raymond Sanderson, Clayton D. Washburn, A. K. Wilson. *Lake-land:* R. L. Cline. *Ocala:* Carney W. Mimms.

*Orlando:* L. C. Ingram, Hewitt Johnston. *Pensacola:* Nathan S. Rubin. *Tampa:* H. J. Blackmon, Blackburn W. Lowry.

\* \* \*

Dr. Howard C. Naffziger of San Francisco, president of the American College of Surgeons, was guest of honor and principal speaker at a dinner in the George Washington Hotel, Jacksonville, recently. The dinner was attended by Fellows of the American College of Surgeons from the northeast section of Florida. Arrangements were under the direction of Dr. Frederick J. Waas, of Jacksonville.

\* \* \*

Dr. H. Marshall Taylor, past president of the Southern Medical Association, was the guest speaker at the third annual banquet of the University of Florida chapter of Alpha Epsilon Delta, honorary pre-medical fraternity, on February 13. The subject of Doctor Taylor's address, which was illustrated by a moving picture film, was "The Otorhinologic Hygiene of Swimming."

Dr. Lee Sharp of Pensacola announces his association with the Medical Center of that city. Doctor Sharp is limiting his practice to urology.

\* \* \*

Dr. and Mrs. W. M. Rowlett of Tampa attended the convention of the South Atlantic Association of Obstetricians and Gynecologists at Charleston, South Carolina, February 11 and 12. Doctor Rowlett read a paper before the Association.

\* \* \*

Dr. Raymond Sanderson of Jacksonville was recently appointed as airline pilots' medical examiner by the Civil Aeronautics Authority of Washington. This Authority is the newly created Federal commission which has charge of all aviation regulations and activities, formerly handled by the Bureau of Air Commerce.

\* \* \*

The Annual Conference on Tuberculosis, sponsored by the Florida Tuberculosis and Health Association, is scheduled for Sarasota, April 3-5, inclusive. Dr. T. Z. Cason of Jacksonville, is chairman of the Program Committee.

Dr. P. P. McCain, Director of Tuberculosis for the State of North Carolina, will be guest speaker at a scientific session Monday night, April 3. Medical societies in that area are cooperating. Dr. M. Jay Flipse, Miami, chairman of the Tuberculosis and Public Health Committee, Florida Medical Association, will preside.

Tuesday morning several papers by local and out-of-state speakers will be given and Tuesday afternoon there will be a general session dealing with the medical and sociological aspects of tuberculosis. There will be a banquet Tuesday night and Wednesday morning a round-table on Rehabilitation of the Tuberculous will be conducted.

Programs will be mailed to members of medical societies in advance of the meeting.

The dramas in the series of weekly radio programs by the American Medical Association and the National Broadcasting Company for April, which will deal with the general subject "Health Education," have been announced as follows:

April 5—Don't Believe Everything!

April 12—Learning to Live.

April 19—Accidents Don't Just Happen.

April 26—What is a Doctor?

This program is broadcast over the Blue network of N. B. C. each Wednesday at 2 p. m., e. s. t.

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The following doctors from Florida attended the annual meeting of the American Academy of Orthopedic Surgeons, held at Memphis, Tennessee, in January: Doctors Charles B. Mabry and Paul H. Martin, Jacksonville; and Doctor Arthur H. Weiland of Coral Gables.

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#### OMER R. ALEXANDER

Dr. Omer Rocelus Alexander of Winter Haven died at a Dunedin hospital on January 25, 1939, at the age of 66.

Doctor Alexander was born in Marietta, Georgia, November 19, 1872, and received his education at Emory University, then known as the Atlanta Medical School, from which he graduated in 1893. The following year he was married to Miss Pearl Lott.

He practiced medicine in Quincy, Florida, and Atlanta, Georgia, before moving to Winter Haven for his health in 1919. He continued his practice there and entered the citrus business as a grove owner. He was on the staff of the local hospital since its beginning.

Doctor Alexander was a Mason and a member of the Polk County Medical Society, the Florida Medical Association and the American Medical Association.

Survivors include his wife, Pearl Lott Alexander; four sons, Omer and Henry of Winter Haven, Robert of Atlanta and Merritt of Cincinnati; three daughters, Mrs. B. A. Morton of Atlanta, Mrs. James Hussey of Dunedin, and Mrs. Kenneth Recker of Winter Haven.

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## ALFRED COMER KNIGHT

Dr. A. C. Knight, 63, a practicing physician in Jacksonville for about a quarter of a century, died February 11, following a brief illness.

A native of Butler County, Alabama, Doctor Knight came to Jacksonville about forty years ago after graduating from the University of Alabama with a degree in pharmacy. After practicing pharmacy with a local drug firm for a period of time, he matriculated at the Charleston College of Medicine and graduated from that institution with a medical degree in 1911, returning to Jacksonville to become a general practitioner.

Doctor Knight is survived by his widow, Zellah Adelle Knight of Jacksonville; one son, Frank T. Knight of Lake City; and two sisters who reside in Alabama.

## BIRTHS AND DEATHS

### BIRTHS

Dr. and Mrs. E. J. Thomas of Miami Beach announce the birth of a daughter, Lilaine Jewell, on February 13, 1939.

\* \* \*

### DEATHS

Dr. Omer R. Alexander of Winter Haven died in Dunedin on January 25.

\* \* \*

## HOSPITALS

The first organization meeting of the Ft. Pierce Memorial Hospital, Inc., was held February 13. By-laws were adopted. A report from the trustees indicated that \$48,015.83 had been received from contributions. Proposals of twelve bids for hospital equipment were referred to the architect for tabulation. It was expected that contracts, subject to P.W.A. approval, would be awarded upon submission of his report. The estimated cost of this hospital is \$80,000.

\* \* \*

The new and entirely fireproof nurses' home at the Florida State Hospital, Chattahoochee, was formally occupied January 18. The new building takes the place of the one totally destroyed by fire about two years ago. It is three stories in height, of reinforced concrete, has two large wings and contains 290 dormitory rooms. The structure cost approximately \$350,000 and was built with state and federal aid funds.

\* \* \*

President Roosevelt has approved the Pensacola convalescent hospital project, sponsored by the local Exchange Club, according to a telegram received by the *Pensacola News* from Congressman Millard Caldwell. The approval carries a government appropriation of \$10,956 which is to be added to an unspecified sum tendered by an unnamed donor for the convalescent hospital.

## COMPONENT COUNTY SOCIETIES

### BAY COUNTY MEDICAL SOCIETY

The Bay County Medical Society met February 7. Dr. W. C. Roberts entertained the members and visiting doctors at the St. Andrews Bay Yacht Club where a dove supper was served.

The following program was enjoyed: Dr. C. C. Webb of Pensacola, gave a report as District Councilor, and also read a paper on "A Plea for Rectal Examination." Dr. A. W. White of Pensacola discussed "Management of the Healthy Infant During the First Year of Life." Dr. C. J. Heinberg of Pensacola presented a very interesting motion picture of work done by the staff of the Medical Center of Pensacola. The picture dealt with intrinsic carcinoma of the larynx and vocal cord, its removal and results; removal of appendix, usual technique; repair of strangulated inguinal hernia; classical cesarean section; operation for pyloric stenosis. Drs. W. P. Hixon and Lee Sharp of Pensacola were also present and made a few remarks.

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### BREVARD COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Brevard County Medical Society was held Thursday evening, February 2, at the Brevard Hotel in Cocoa. After a delicious dinner, the scientific program was held. The guest speakers of the evening were Dr. William E. Lower and Dr. A. Carlton Ernstene of the Cleveland Clinic. Doctor Lower's address was on "Some of the Changes in Modern Medicine." Doctor Ernstene took for his theme, "Common Errors in Cardiac Diagnosis."

The local society was honored by the presence of many visiting doctors: from Orlando, Drs. Russell B. Carson, Frank H. Harms, John R. Hatfield, Hewitt Johnston, Duncan McEwan, Meredith Mallory, Fred Mathers and J. A. Pines; from Daytona Beach, Drs. J. E. Rawlings, J. Ralston Wells and Evans B. Wood; from New Smyrna, Drs. L. B. Bouchelle and Harry Z. Silsby; and from Oviedo, Dr. J. W. Martin. Dr. L. L. Anderson of Cocoa, a dentist, was also present as a guest.

The following members of the Brevard County Medical Society attended: Drs. I. F.

Bean, G. E. Christie, W. J. Creel, I. M. Hay, I. K. Hicks, T. C. Kenaston, W. C. Page and G. T. Von Colditz.

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BROWARD COUNTY MEDICAL SOCIETY

The Broward County Medical Society, with a membership of 33, has reported 100% of 1939 dues. This society which draws its members from Ft. Lauderdale, Hollywood, Pompano, and Dania, is headed by R. L. Elliston, president; F. D. Pierce, vice-president, and O. C. Brown, secretary-treasurer.

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DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society held its February meeting on the evening of the 7th, in the Ingraham Building.

The scientific program consisted of a symposium on "Peripheral Vascular Diseases," presented by Drs. S. Charles Werblow and George D. Lilly. Drs. Robert M. Harris and John W. Snyder opened the discussion.

\* \* \*

DUVAL COUNTY MEDICAL SOCIETY

The regular meeting of the Duval County Medical Society was held February 7 in the Library of the State Board of Health. Dr. T. E. Buckman, president, presided.

The scientific program was in charge of Dr. George Croft, who introduced Judge Criswell, who spoke on behalf of the Community Chest. Dr. K. K. Waering gave an interesting outline of the program, functions and aims of the Duval County Health Unit, stressing the emphasis placed on the public to periodic health examination. The history of the city health was portrayed in an interesting manner by Dr. N. A. Upchurch. As president of the County Medical Society at that time, Doctor Upchurch initiated the movement toward obtaining a full-time health officer and in 1910, Doctor Terry was appointed the first full-time health officer of the city of Jacksonville. From that time to the present, the marked improvement in the health and sanitation of this city was traced.

A business meeting followed at which Drs. John A. Beals and Joseph Weinreb were voted into membership of the Society. Guests of the Society were Doctors Buck and Amyot of the American Public Health Association.

Dr. Lucien Y. Dyrenforth and Dr. W. McL. Shaw gave an illustrated lecture on "Radiology and Pathology of Tumors, Malformations and Surgery of the Mouth and Jaw" before the Northeast District Dental Society's semi-annual meeting, February 25 in the Club Room of the George Washington Hotel, Jacksonville. The members of the Duval County Medical Society were invited as guests.

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FRANKLIN-GULF COUNTY MEDICAL SOCIETY

The Franklin-Gulf County Medical Society held its January meeting Thursday evening, January 19 at Wewahitchka, with Dr. Thomas Meriwether as host. During the business session a motion to adopt a recommendation concerning the farm relief program of the government, providing medical care for certain farmers and their families, was passed. After the business session, the physicians were served a chicken supper with all the trimmings. The ladies attended to the proper preparation and serving of the sumptuous meal. Those in attendance were Drs. A. E. Conter, A. L. Ward, L. H. Bartee and J. R. Norton. Doctor Parmenter, county health physician, attended as a guest. It was decided to hold the next meeting of the society in Carrabelle February 16.

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PALM BEACH COUNTY MEDICAL SOCIETY

Dr. Jerome M. Lynch of the Postgraduate Hospital, New York, spoke to the members of the Palm Beach County Medical Society at a special meeting early in February, at the nurses' home of the Good Samaritan Hospital, West Palm Beach. His lecture on diseases of the lower intestinal tract was accompanied by motion pictures of surgery for such cases. Dr. Gaylord Lewis, president, presided at this special meeting.

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PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. and Mrs. G. R. Creekmore of Brooksville entertained the Pasco-Hernando-Citrus County Medical Society at their home Thursday evening, February 9. A Swiss steak dinner was served, following which a business and scientific meeting was held.

The minutes of the last meeting were read and adopted. A motion was made and car-

ried to extend the time of voting on the charter until the March meeting. The following were selected as Trustees of the Society: Drs. S. C. Harvard, W. W. Jones, George A. Dame, R. D. Sistrunk and J. T. Bradshaw.

Those present were Drs. H. L. Harrell, C. L. Carter, G. R. Creekmore, S. C. Harvard, George A. Dame, W. W. Jones, W. H. Walters, J. T. Bradshaw, and David B. Manley, all of whom gave interesting case reports.

Dr. George A. Dame invited the Society to hold its March meeting with him in Inverness.

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#### PINELLAS COUNTY MEDICAL SOCIETY

Two meetings were held of the Pinellas County Medical Society during the month of February.

Dr. C. A. Williams of St. Petersburg was principal speaker at the February 3 meeting, using as his subject "Digitalis." The discussion was opened by Drs. R. H. Knowlton and A. S. Anderson.

On February 17, Dr. Clark D. Brooks of Detroit was the Society's guest speaker. Doctor Brooks, who is Associate Professor of Clinical Surgery at the Detroit College of Medicine and Surgery, spoke on "Surgery of the Gall Bladder."

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#### SEMINOLE COUNTY MEDICAL SOCIETY

The Seminole County Medical Society stands 100% paid for 1939. The officers of this society are: president, T. F. McDaniel; vice-president, W. H. Garner; secretary-treasurer, Douglas G. Scott. Doctor McDaniel has been elected as delegate to the state convention in May.

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#### WASHINGTON-HOLMES COUNTY MEDICAL SOCIETY

At the January meeting of the Washington-Holmes County Medical Society, the following officers were elected: president, W. D. Ramsey, Noma; secretary-treasurer, L. H. Paul, Bonifay.

The members of the Society expressed their desire to continue meeting once a month as in the past, and to endeavor to have a scientific program of two good papers at each meeting.

### ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Sacral Teratoma Complicating Labor—TRIBBLE, CHARLES E., DeLand, *Yale J. Biol.* 11: 45-47 (Oct.) 1938.**

A case of persistent face presentation, possibly dependent upon a change in the fetal center of gravity due to a sacral teratoma is described by the author.

After three rotation procedures, with the head always returning to a face presentation, podalic version was resorted to. However, on attempting extraction, the breech became fixed in the superior strait. The mother was then allowed to come out of anesthesia and proceed with labor. After 30 minutes, assisted by gentle traction, the breech was delivered and the obstructing body was seen to be a sacral tumor.

The tumor was removed on the 5th day under local anesthesia and was found to contain three separate cysts containing a great variety of histological structures.

**Arthus's Phenomenon from Mosquito Bites: Report of a Case with Experimental Studies, BROWN, ALAN; GRIFFITHS, T. H. D.; ERWIN, STANLEY; and DYRENFORTH, LUCIEN Y., Jacksonville, *South. M. J.* 31: 590-596 (June), 1938.**

Arthus's phenomenon is the local necrosis of tissue in the skin at the site of injection of a foreign protein, which had previously been injected in the blood. It is a local anaphylaxis. The authors report a case in which such local necrosis was produced by the bite of *Aedes aegypti*, a common household mosquito. Such a manifestation of the phenomenon of Arthus is unique.

The patient, a 15-year old girl, had a long standing skin condition caused by mosquito bites (according to the patient). When 2½ years old blebs of the skin were first noted. At 7½, the blebs had increased in size and number, and, invariably followed a mosquito bite. At age 9, necrosis of tissue under the bleb followed regularly after such bites. By 1930 the seasonal incidence was obvious, but the lesions produced induration and hardness



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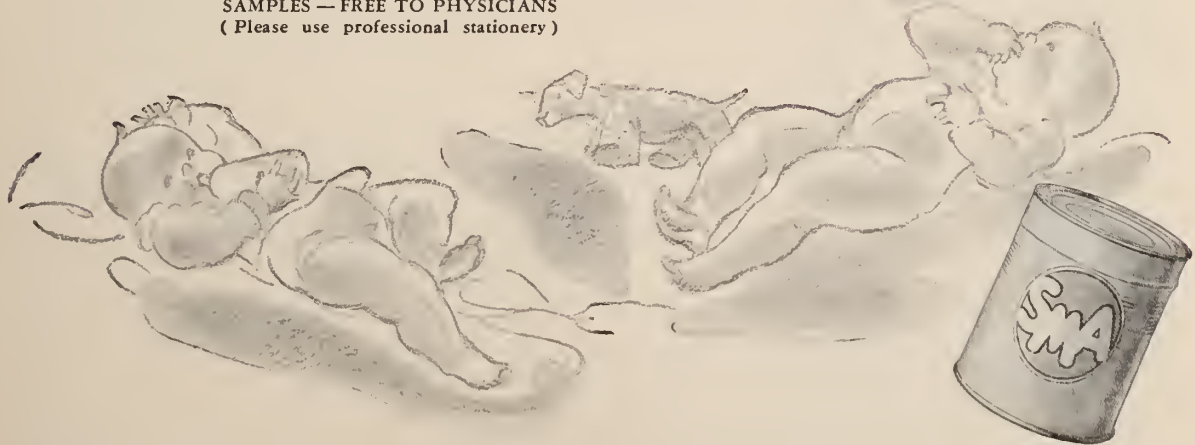
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which persisted long after the mosquito season.

Experimentally these lesions could be reproduced in the patient by bites of the *Aedes aegypti* mosquito, but not by the bites of other mosquitoes or injections of venoms, food, or other allergens. The details of the experimental work and the authors' exhaustive study to discover the nature of this allergic manifestation deserve careful study by anyone interested. That desensitization by injection of increasing amounts of mosquito extract was unsuccessful does not nullify the conclusions as to the allergic cause, but rather leads the authors to a careful study of the problem of local immunity and the possibility of prevention of such local necrosis.

#### ATTENTION TO ADVERTISEMENTS

The fact has often been mentioned that income from advertisements forms the backbone for the existence of any publication. This is as true for medical as other magazines. One form of advertising appeals particularly to the reader, in which the advertiser seeks personal contact with him by means of the coupon which one is requested to detach and mail to a given address. The advertiser usually has samples of his products which will be distributed to all inquirers making use of the coupon. If the reader will pay attention to these and utilize them as requested, the interest thus displayed will be advantageous in promoting the well-being of the journal in which he is personally interested.

#### BOOKS RECEIVED

**SURGICAL PATHOLOGY OF THE DISEASES OF THE MOUTH AND JAW.** By A. E. HERTZLER, M. D., Surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, and Professor of Surgery, University of Kansas. This is the tenth and last volume of the series of monographs on Surgical Pathology written by Doctor Hertzler. The work is divided into twelve chapters, as follows: General Consideration of Surgical Affections of the Mouth and Jaws; Nonmalignant Disease of the Lips; Malignant Tumors of the Lips; Benign Lesions of the Mouth and Tongue; Malignant Lesions of the Mouth and Tongue; Granulomatous Tumors of the Gums; Malignant Tumors of the Jaws; Tumors of Dentigerous Origin (Mixed Tumors); Diseases of the Palate; Diseases of the Nasopharynx; Inflammatory Lesions of the Jaws; and Diseases of the Larynx. Two hundred six very clear-cut illustrations—pictures and drawings—enrich the volume. In his Preface, the author states: "I have always found it impossible to write of things that I have not seen. Therefore, many of the things described in other books I have not mentioned because I have not seen them. I have traveled a long ways so that I conclude that what I have not seen must be rare and it is fair to hope that likely the majority of surgeons will live a lifetime without seeing them." Cloth, pp. 248; price, \$5.00. Philadelphia: J. B. Lippincott Co.



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## SQUIBB INSTITUTE FOR MEDICAL RESEARCH

To provide clinical facilities for the research staff of the new Squibb Institute for Medical Research, a plan of hospital affiliation is being worked out by the Division of Experimental Medicine. A free ward of fifteen or twenty beds will be maintained for the observation of patients in connection with various problems being studied at the Institute.

Under the direction of the Division of Experimental Medicine, new fellowships in medical schools will be established by the Institute for the study of cancer, syphilis, and hormones. Other fellowships now sponsored by Squibb and Sons will be continued as part of the Institute's program.

The mechanism of surgical shock is among the researches planned by this Division. The value of certain hormone preparations in the treatment of surgical shock is being tested. Another investigation aims to determine the value of vitamin K in checking hemorrhage after operations. Dr. Stefan Ansbacher, formerly research chemist with the Borden Company, has been named associate in the Division and assigned to the vitamin laboratory.

Research on measles, called the second greatest cause of infant mortality, is being undertaken by the Division of Bacteriology and Virus Diseases. The investigation is directed towards the discovery of a small animal susceptible to measles. The only animal now known to yield to the measles virus is the monkey. Since the monkey is expensive to obtain and to maintain, it is explained, investigation would be facilitated if the scientists were to succeed in finding a small animal like the mouse or guinea pig which is capable of contracting the disease.

The research workers hope to ascertain whether well persons can carry the measles virus in their throats. Dr. Rake and his colleagues are attempting to develop a measles serum that can be standardized to replace the now unstandardized sera. Dr. Rake has already inoculated many monkeys with the measles virus.

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### AUXILIARY NEWS FROM DADE COUNTY

Mrs. Carl E. Dunaway, president of the Auxiliary to the Dade County Medical Association, announces a number of activities in which the Auxiliary is interested. Mrs. Dunaway has interested every member in some phase of the Auxiliary work by placing each one on some committee. Nearly all of the members are actively engaged in some committee work.

The Auxiliary has agreed to sponsor the Medical Library which is located in the James M. Jackson Memorial Hospital. The library was started one year ago by the Dade County Medical Association. This year the Auxiliary has given to the library to date \$200.00. This is to be used in bringing the periodicals up-to-date and to purchase much needed books on surgery, obstetrics, tuberculosis, and other diseases. The money was raised by a dance and a benefit bridge. Mrs. S. Marion Salley is Auxiliary library chairman.

The Auxiliary also has charge of the booth sales of the tuberculosis Christmas seals. Approximately \$700.00 was realized from the Christmas booth sales. In 1937 booth sales in Dade County led the nation in amount of money received according to population of County. Mrs. Scheffel Wright has been Auxiliary booth chairman of the Christmas seals for the past two years.

Mrs. Frank Morrow, treasurer and finance chairman, has set a goal of \$300.00 for this year's work in aiding the library fund and in doing welfare work.

The type of welfare work that the Auxiliary is most interested in is tuberculosis work



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in the wards of Jackson Memorial Hospital. Mrs. Herman Boughton, chairman of this work, reports that \$25.00 was spent recently in the woman's ward in the following manner: bed lamps were purchased for those who did not have them, two rocking chairs were bought, and several pieces of the furniture in the ward were repainted. The committee is very active and enthusiastic and plans to brighten up the wards much more by painting other pieces of furniture and installing book-cases and filling them with readable novels for the convalescents to enjoy.

Mrs. Dunaway is one of those rare personalities who can inspire others to give their best to the work that is being undertaken, as interest in the above activities certainly prove.

Besides these very active local committee officers and chairmen, the Dade County Auxiliary claims as a member Mrs. Arthur L. Walters, president of the Auxiliary to the Florida Medical Association. The county auxiliary is especially proud of the fact that one of its members was chosen to the highest office in the state organization.

The next meeting of the Auxiliary will be the third Monday in April. Auxiliary members will be luncheon guests of the Jackson Memorial Hospital. The members of the Auxiliary will learn how they can further assist the library committee in the Dade County Medical Association.

DRUCILLA BARGE.  
(Mrs. Hubert A. Barge)  
Second Vice-President.

\* \* \*

#### VOLUSIA COUNTY MEDICAL SOCIETY

The members of the Auxiliary to the Volusia County Medical Society are busy working out plans for the entertainment of the State Auxiliary on May 1, 2, and 3. While the host Auxiliary wishes to care for the entertainment and comfort of visitors during their entire stay in Daytona Beach, the schedule of entertainment is being so arranged as to leave ample time for the enjoyment of the world-famous beach.



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SOLOMON, P.; MITCHELL, R. S. AND PRINZMETAL, M.: The Use of Benzedrine Sulfate in Postencephalitic Parkinson's Disease—*J. A. M. A.*, 108:1765, May 22, 1937.

FINKELMAN, I. AND SHAPIRO, L. B.: Benzedrine Sulfate and Atropine in Treatment of Chronic Encephalitis—*J. A. M. A.*, 109:344, July 31, 1937.

DAVIS, P. L. AND STEWART, W. B.: The Use of Benzedrine Sulfate in Postencephalitic Parkinsonism, *J. A. M. A.*, 110:1890, June 4, 1938.

MATTHEWS, ROBERT A.: Symptomatic Treatment of Chronic Encephalitis with Benzedrine Sulphate—*Am. J. Med. Sci.*, 195:448, April, 1938.

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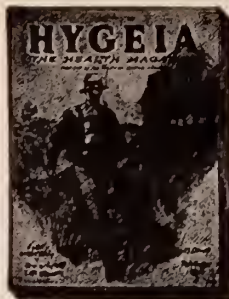
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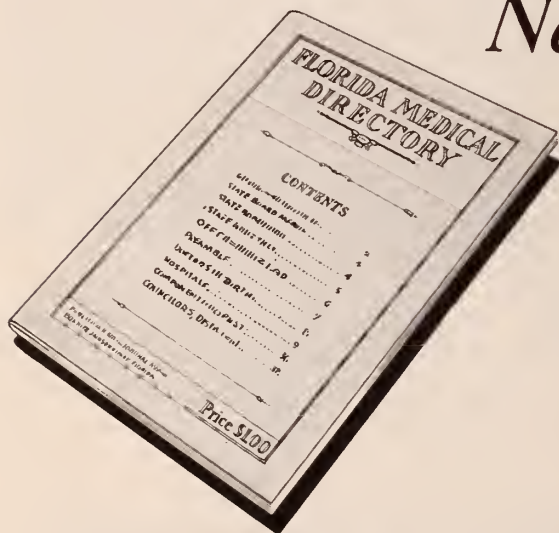
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Districts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Panama City July 21, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	11	
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. Desoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	28
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. B. Spire, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Rausey, M.D. Noma	L. H. Paul, M.D. Bonifay		Santa Rosa	8	
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Fort St. Joe	3rd Thursday	A-2-'39 N. A. Baltzell, M.D. Marianna	7	
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		14	11
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	37	1
North Central District (B) Ocala October 27, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Bianche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M.D. Lake City	20	12
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Ralph J. Greene, M.D. Perry	W. J. Baker, M.D. Koley	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton-Lafayette-Suwannee	8	
	Alachua	J. E. Malnes, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St. S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	29	
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		22	19
	Pasco-Hernando-Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	13
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	Bradford-Gilchrist-Levy-Union	3	2
N. E. District (C) Palm Beach September 15, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M.D. Jacksonville	172	109
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.		10	
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	Clay-Nassau C-6-'40 George M. Green, M.D. Daytona Beach	10	9
	Volusia	Maxmillan Stern, M.D. Box 5098 Daytona Beach	R. L. Miller, M.D. 238½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	39	16
Southwest District (D) Palm Beach September 29, 1939	Hillsborough	J. W. Alsbrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M.D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsbrook, M.D. Plant City	103	
	Manatee	S. G. Hollingsworth, M.D. Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.		14	100%
	Pinellas	E. C. MacCordy, M.D. 627 11th St. N. St. Petersburg	W. C. McConnell, M.D. 1005 Equitable Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		90	89
	Sarasota	T. W. Taylor, M.D. Walpole Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	
	DeSoto-Hardee-Highlands-Chsrlotte-Glades	Ben D. Spears, M.D. Waubula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M.D. Lakeland	20	
	Lee	C. Gordon Merrick, M.D. 26 Leon Bldg. Fort Myers	H. L. Allan, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		13	
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	60	
South Central District (E) Sanford November 10, 1939	Brevard	G. E. Christie, M.D. Titusville	I. K. Hines, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	12	
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		77	39
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M.D. Ft. Pierce	17	16
S. E. District (F) West Palm Beach October 13, 1939	Broward	R. L. Ellison, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	33	100%
	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Harvey Bldg. W. Palm Beach	4th Monday 8:00 P. M.		60	38
	Dade	M. Jay Flipse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M.D. Miami Beach	282	
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	



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# The JOURNAL

of the

## Florida Medical Association, Inc.

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### NEXT SESSIONS

American Medical Association, St. Louis, May 15-19, 1939  
Florida Medical Association, Daytona Beach, May 1, 2, 3, 1939  
Southern Medical Association, Memphis, November 21-24, 1939





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Ar. Chattanooga, C. N. & St. L.	10:05 P. M. May 13	1:20 P. M. May 14
Ar. Nashville, C. N. & St. L.	2:00 A. M. May 14	5:10 P. M. May 14
Ar. St. Louis, L. & N. RR.	11:43 A. M. May 14	7:45 A. M. May 15

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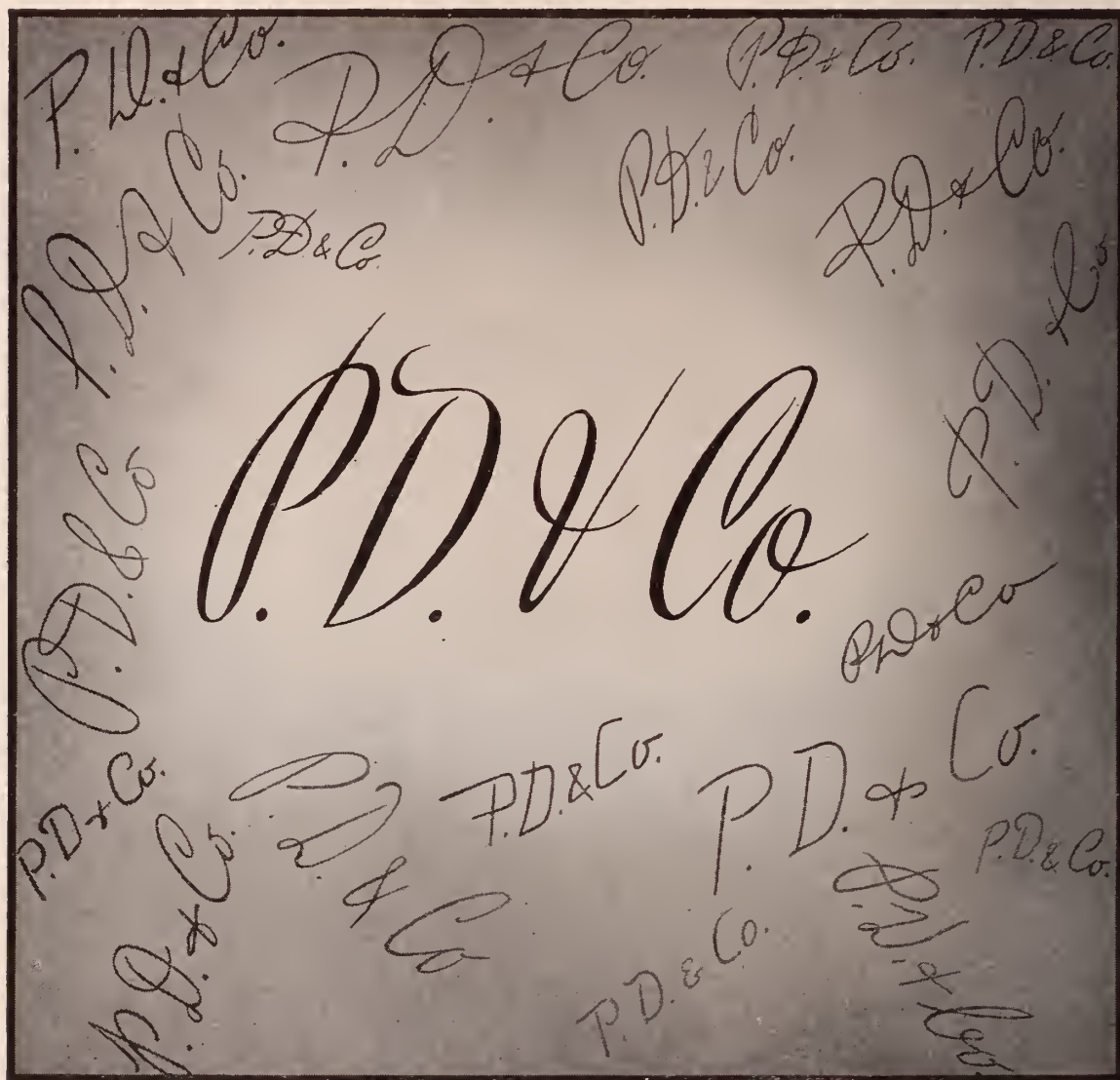
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(1) 1937. Am. J. Digestive Diseases,  
Nutr. 4, 240.

(2)a. 1933 J. Am. Diet. Assn. 9, 295.  
b. 1934. J. Nutrition 8, 449.

(2)c 1936. Ibid. 12, 405.

d. 1936. J. Am. Diet. Assn. 12, 231.

(3) 1932. J. Pediatrics 1, 749.

(4) 1938. Am. J. Diseases Children 55, 1158.

*We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-seventh in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.*



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## AGRANULOCYTOSIS AND SULFANILAMIDE

N. L. MARCUS, M. D.,  
Tampa.

With the introduction of a new drug of popular usage, containing the benzene ring, the question of agranulocytosis again comes to the front. Such a drug is sulfanilamide, which is probably one of the most used of all drugs today. We have seen many toxic symptoms due to this drug, such as anemias, skin rashes, toxic effects on the blood stream, and now agranulocytosis. Certainly the number of reported cases of agranulocytosis due to this drug are relatively small considering its various uses in medicine, since its introduction a few years ago. The Quarterly Cumulative Index Medicus up to Sept. 1937, reports only two cases of agranulocytosis, one by C. J. Young<sup>1</sup> and one by J. G. Borst<sup>2</sup> both of which were fatal. Other authorities mention this occurrence in sulfanilamide treated persons, but case histories are not reported.

At this time a repetition and review of the literature is indicated.

### DEFINITION

Agranulocytosis, also known as malignant neutropenia and agranulocytopenia, is a symptom complex of still unknown etiology, either acute or chronic, characterized by peculiar ulcerations or gangrenous lesions occurring in the mouth or throat or other mucous membranes; also by a marked reduction in the total number of white cells, and a great reduction in the percentage of granulocytes. In most cases a rapidly fatal course ensues.

### HISTORY

Schultz in 1922 is given credit for describing this disease, and naming it. Pepper,<sup>3</sup> in his article in 1931 on "The History of Agranulocytic Angina" stated that standard laryngologic works of fifty years ago, apparently described this disease under the heading "putrid sore throat" and "gangrenous angina" and that Mackenzie in his manual on dis-

eases of the throat and nose credited Gubler in 1857 and Trousseau in 1865 with clearly distinguishing the disease from diphtheria. Cases have been reported by Brown<sup>4</sup> in 1902, by Turk<sup>5</sup> in 1907, and by Leale<sup>6</sup> in 1910 which undoubtedly were cases of agranulocytosis. However, certainly agranulocytosis had not existed to any great extent prior to 1902, because hospitals had been doing blood counts for the past 65 years, and such cases would certainly have been reported.

### CLASSIFICATION

Cases are divided into two main classes: idiopathic or primary agranulocytosis in which the etiology is unknown; and secondary agranulocytosis in which the etiological agents are apparently evident or in which one is dealing with examples of well recognized clinical entities.

Further subdivisions into clinical types are: the acute fulminating type which is rapidly fatal; the subacute type in which the illness is more prolonged, lasting 1-3 weeks, and usually recurring; the recurring or relapsing type in which death may occur either in the first or later attacks, or the disease may become subchronic; the subchronic type which may last a year or more with either fatal or recovery termination; the cyclic type which is chronic, regular, recurring periodic neutropenia. One case<sup>7</sup> reported of this last-named type presented a neutropenia at approximately 25-day intervals for over 20 years.

### ETIOLOGY

Explanation of the pathogenesis of this disease rests on hypothesis alone as the etiology is still not definitely proven. I shall present a few of the more common suggestive causes of this disease.

1. Predisposing Causes: Certain people run a neutropenia of a slight degree constantly, and it is possible that the disease is more frequent in this group. There is no direct evidence to confirm this. This disease occurs most commonly in midadult life, with the peak in the 50's. It occurs in women three and one-half times as frequently as in men. It

<sup>1</sup>Read before the Hillsborough County Medical Society, January 4, 1938.



occurs mostly in doctors, nurses, dentists or their families. There are no familial relationships or tendencies.

2. Diet Deficiency in Vitamin B and G: This may play some role in the experimental production and clinical development of this disease.

3. Infection: Overwhelming infection can in all probability be discarded as a common cause, but that it may be an occasional one need not be denied. Sepsis is usually the result rather than the cause.

4. Allergy has been suggested since we do see cases following the administration of anti-toxins, but that allergy is of major importance is to be shown.

5. Endocrine: Because one case<sup>7</sup> has been reported recurring regularly for over 20 years at 25-day intervals, and because the disease frequently begins with menstruation, an endocrine theory has been suggested. There has been no definite evidence to confirm this.

6. Chemical poisoning: Chemical poisoning of the granulocytes is possible, but usually drugs do not have an affinity for just the granulopoietic tissue. Benzene and drugs containing the benzene ring could be an etiological factor. These drugs may serve to weaken the hematopoietic tissue. Benzene does not usually produce typical leukopenia, but a depression of all bone marrow elements so that anemia, purpura as well as neutropenia are produced. However, the benzene drugs have been administered to produce neutropenia. Kracke and Parker<sup>8</sup> recorded that there was constantly increasing evidence that the condition was caused for the most part by easily oxidizable benzene ring drugs. The typical agranulocytosis has not been produced as yet in animals. Other drugs such as dinitrophenol, arsphenamine, acetanilid, bismuth, gold compounds, x-rays, and gamma rays of radium have apparently been shown to produce agranulocytosis. The most common drug blamed for this condition has been pyramidon or amidopyrine, and now sulfanilamide. Development of symptoms probably depends on individual idiosyncrasies to drugs because thousands of people have taken these drugs without any untoward effects. There is probably, as many authorities now believe, some underlying bone marrow dyscrasia in these cases.

7. Many cases occur without any drugs being administered. When all is said and done, it must be confessed that the etiology of this disease still remains in the large part obscure.

#### PATHOLOGY OF THE BONE MARROW

The pathology of this disease is still in dispute. The bone marrow may show either aplastic, normal or hyperplastic myeloid tissue, depending on the type of the disease, and the stage in which the bone marrow study is made. In patients dying of the acute fulminating disease, the bone marrow was found to be rich in white blood cells, but in patients dying at a later stage, there was more hypoplasia. In most deaths there was a marked change in the granular series. No mature granulocytes nor any true myelocytes were found, but practically every cell belonging to the granulocyte series was a stem cell. This is the usual bone marrow pathology found. This is interpreted as a maturation arrest. Later in the disease, the lymphocytes, and plasma cells replace the previously existing stem cells.

Apparently two types of changes underly these cases:<sup>9</sup> 1. Maturation of the granulocytes has ceased, and there are peripheral neutropenia, and myeloid aplasia. 2. In the other type there is arrest of maturation with peripheral neutropenia and normal or hyperplastic myeloid tissue.

#### PATHOLOGICAL PHYSIOLOGY

The absence of the neutrophils lowers the resistance and results in the invasion of the mucous membranes by organisms ordinarily present. The blood culture is positive in about one-third of the cases. With such a condition septicemia with all its complications may occur.

#### SYMPTOMS

The onset is usually acute, rarely chronic. The clinical history is that of an acute infection with chills, fever, and marked prostration. There may or may not be a sore throat or involvement of the mucous membranes. Jaundice occurs in about one-half the cases. Hemorrhagic tendencies are rare. The throat pathology or involvement of the mucous membranes, especially of the tonsils, pharynx, gums, tongue or larynx, occasionally of the skin, vagina or rectum may be the findings

which suggest a blood examination. The ulcers are very peculiar and only rarely absent. They are non-marginated, with overhanging edges, and there is a complete absence of surrounding inflammatory reaction.

Edema of the throat may render swallowing impossible. The mucous membranes may be covered by a whitish or yellowish membrane, and many cases are admitted under the guise of diphtheria. The cervical lymph nodes are usually enlarged. The liver and spleen are palpable in some cases. Death may occur in a few days or a week. Temperatures range about 104°,—rarely 106° and 107°,—and remain constant.

#### LABORATORY FINDINGS

The urine contains albumin; and bile in cases which are jaundiced. The blood examination is characteristic. A progressive fall in total white blood count usually accompanies the disease. In 82 cases reported and reviewed by Cecil,<sup>10</sup> the average count was 1210, and lowest 100. The polys are reduced on the average to 4 per cent or may be absent. These figures agree with most records. In 90 per cent of the cases there are no changes in the red blood count, blood platelets or hemoglobin.

There is a relative lymphocytosis although the absolute number is normal or less. During convalescence there is an increase in platelets. The blood culture is positive in one-third of the cases. A great variety of organisms have been isolated, including the pneumococcus, streptococcus, staphylococcus, Friedlander's bacillus, colon bacillus, and bacillus pyocyaneus. Cultures from the lesion reveal a large number of organisms, those from the oral cavity usually being Vincent's.

#### DIAGNOSIS

A leukocyte count under 2000 per cu. mm. with very few neutrophils will differentiate agranulocytosis from most cases of stomatitis or sore throat or conditions mimicking agranulocytosis except aplastic anemia, and aleukemic leukemia. Sternal biopsy is a useful and in some cases a necessary diagnostic procedure. However, let me mention some conditions with which agranulocytosis may be confused.

1. A secondary or symptomatic agranulocytosis may occur in acute toxication from

benzol, thorium, arsenic, gold, bismuth, x-rays, and radium.

2. Atypical cases of acute aleukemic leukemia. Here we encounter real trouble. In 1931 Jackson and Parker<sup>11</sup> published a case of a man suffering from granulopenia who temporarily recovered following pentnucleotide therapy only to succumb to classical leukemia four months later. The postmortem sternal bone marrow was characteristic of acute leukemia. Since 1931 these authors have seen two other similar cases. Brogsitter<sup>12</sup> has noted similar cases. However, in the typical cases the two diseases may be easily differentiated, but in some, differentiation is impossible. In other cases of chronic leukemia, patients die with terminal blood picture of agranulocytosis, and the bone marrow is aplastic in many places. In the typical cases a high percentage of primitive cells in the peripheral blood as myelocytes and myeloblast point toward a leukemia. A sternal puncture will as a rule differentiate these cases, especially if a progressive chronological series is made. As a rule enlargement of the lymph nodes and spleen does not occur in agranulocytosis but may also be absent in leukemia. However, the sternal bone marrow in leukemia shows a great increase in promyelocytes, prolymphocytes, promonocytes, or proplasmocytes according to the type of leukemia present. It is noteworthy that the same type of lesions of the mucous membranes may occur in each, and may have a marked decrease of neutrophils in the blood.

Absence or marked diminution of platelets, anemia of moment, particularly if progressive; hemorrhages, especially from mucous membranes of the mouth; notable enlargement of the spleen and enlargement of the lymph nodes, not readily explainable by adjacent ulceration and infection, all bespeak the diagnosis of acute leukemia. During the convalescence from agranulocytosis, there may be, and in fact usually is, a transient outpouring of myelocytes, but this stage is soon passed and clinical improvement is coincidentally evident. Leukemic patients with temperatures of 102°-104° may seem comparatively well; this is rarely the case with agranulocytosis. Temperature is intermittent in leukemia, but in agranu-



locytosis this is more steady. Sometimes there is no fever in leukemia. The total white count is of no vital importance since leukemia is still leukemia whether the white count is 500 or 50,000. Leukemia occurs in younger people as a rule.

For the present the relationship of the two conditions must be regarded as problematic.

3. Aplastic anemia patients usually have a profound anemia, hemorrhagic diathesis and low platelet count, with absence of reticulocytes. The onset of fever is usually not so abrupt. The bone marrow in aplastic anemia is yellowish, and shows almost complete absence of nucleated cells as well as the cells of the granulocyte series. History of organic arsenicals, benzol exposure or overdosage of x-rays or radium may be obtained.

4. Infectious mononucleosis is a more benign condition and a definite leukocytosis is present at some stage. Injection of foreign protein in cases of low white blood count will result in an increase in circulatory neutrophils. Clinical manifestations are less severe. The sheep cell heterophil antibody test is of practical value in differential diagnosis. Fenestration of the cells is also an important point.

5. Diphtheria by culture and blood count.

6. Vincent's stomatitis by culture and normal blood picture. However, certain cases of Vincent's stomatitis are really agranulocytosis.

7. Care must be taken also to distinguish pernicious anemia in an aplastic phase, and malignant metastasis to the bones producing the so-called myelophthisic anemia.

#### HEMATOLOGICAL CONSIDERATIONS

Hematological considerations<sup>13</sup> regarding the interrelationship between agranulocytosis, progressive erythrophthisis, some types of purpura, and aplastic anemias are very interesting. These are closely related, and a condition beginning with one may later develop any possible combination of these syndromes or all three.

Each condition signifies a more or less complete cessation of multiplication in particular cell series involved without maturation: the first, the granulocyte series; the second, i. e., progressive erythrophthisis, (a very rarely known disease, apparently cessation of formation of cells of erythrocyte series); the third that of the thrombocyte series; and the last more or less a combination of these.

The particular member of this group which an individual may develop depends on dosage of causative agent, and in part on individual idiosyncrasy. For example benzene in humans usually produces aplastic anemia; aminopyrine produces agranulocytosis; and arsphenamine produces either one with equal frequency. Each of these syndromes may be produced by organic arsenicals, idiosyncrasy to benzene compounds, or overdosage of gamma or alpha rays.

#### PROGNOSIS AND COURSE

The prognosis is always grave, mortality ranging in the cases from 85 per cent to 90 per cent reported by Cecil.<sup>10</sup> The course is rapid, the shortest being two days, the longest being 90 days. The chronic and recurring cases may last as long as five to twenty years.

In 1931, Taussig and Schnoebelen<sup>14</sup> gave a mortality of 76 per cent in 330 collected cases. In 1934, Roberts and Kracke,<sup>15</sup> stated that complete granulopenia is usually a fatal disease during the first or later attacks, and these authorities say that they have not seen any of their recovered patients return to complete health. This, however, is not in accordance with other authorities.

The prognosis is better when some drug is of etiological significance. With the use of pentonucleotide, Jackson and Parker<sup>16</sup> in 108 cases report a mortality of only 33 per cent. Pentonucleotides offer the best prognosis. The lower the white blood count, the higher the mortality; the higher the temperature, the higher the mortality.

In the chronic cases, the prognosis is better than in the acute.

#### TREATMENT

The major problem is that of restoring bone marrow to its normal activity. Without bone marrow recovery, there can be no cure. Beckman<sup>17</sup> states that it is altogether impossible to truly evaluate the different forms of treatment at the present time for several reasons: the tendency toward spontaneous recovery naturally invites a claim of cure for the last agent used; it is not yet known how many recoveries are really only remissions; and there are records of response to a given agent in one attack, and failure to respond to the same agent in a subsequent attack.

Many other authorities believe that recov-



ery when it does take place is spontaneous, and not influenced by the type of treatment. There are many definite cases of agranulocytosis when recovery has been spontaneous. However, the average case is normally not left to this opportunity. Treatment must be directed to the acute and to the chronic cases. We know that the mere absence of granulocytes for seven days is incompatible with life.

I shall mention a few of the more commonly used types of treatment:

*Drugs:* All drugs containing the benzene ring should be immediately discontinued. However, cases are reported in which patients have recovered in spite of continued administration of these drugs. This procedure is not to be recommended, however.

*The Treatment of the Local Lesions:* Application of a saturated solution of sodium perborate or a two per cent solution of copper sulfate to the lesions as often as five times a day is advised. Gargles with sodium perborate are very beneficial for oral hygiene.

*Surgery:* It is most important to localize and drain any abscesses or foci of infection containing pus. Surgery should be undertaken as advised in a patient with normal blood. Retrocecal abscesses have been drained, thorocotomy for empyema has been done, amputations have been performed, and cervical areas have been drained, and in most of these cases recovery has ensued. Some authorities, however, believe that surgery should never be attempted with these patients, but it is noteworthy that some patients have recovered only after surgical intervention.

*Nonspecific Therapy:* Nonspecific therapy such as foreign protein (milk) is conceded to be useless.

*Vitamins:* A high vitamin diet of Vitamin B and G in chronic cases seems to have some value.

*Blood Transfusion:* Blood transfusions do not have a stimulative effect on the bone marrow or a curative effect. Indeed, it is not uncommon for the white count to drop after a transfusion. Nevertheless, blood transfusions do play a part in tiding over a patient until the time when he is able to produce his own granulocytes. The blood of patients who have recovered from this disease seems to be of more value in these transfusions.

Bock<sup>18</sup> in 1937 treated successfully one patient with the blood of a patient who had myeloid leukemia but states that Schittenhelm was the first to prove this procedure. In the stage when the white count is beginning to rise, small transfusions seem to be of definite value. In the acute stages, small transfusions repeated frequently are of the most value.

*X-Ray:* X-ray therapy can be a two-edged sword and does not seem to be of proven value. Many authorities recommend x-ray therapy to the long bones. Osgood and Ashworth<sup>19</sup> state that x-ray is contraindicated.

*Liver:* Liver extract in large doses seems to be of definite value. At present it can be said that the value of liver therapy can not be estimated. Apparently it is of more value in the chronic stages. One case of five years' duration<sup>19</sup> was successfully treated with liver, and many authorities have obtained good results with liver alone in the acute cases.

*Adenine Sulfate:* This is one of the breakdown products of pentnucleotides, and Reznikoff<sup>20</sup> has used this drug with good results. The dosage is 15 grains intravenously three to four times daily for three or four days.

*Pentnucleotides:* Pentnucleotides apparently seem to offer the best possibility of reducing the mortality of this disease. Many authorities have used this drug with good results. It was first reported in 1931 by Jackson and Parker.<sup>18</sup> In the severe case 40 cc. a day is recommended, part of which may be given intravenously. Large doses such as this are given until the blood picture has remained normal for three days. Smaller doses have been recommended in the less severe cases. No change in the blood picture is to be expected until the fourth or fifth day, and then there is an increase in the myelocytes in the blood stream, and in the total white count. Shortly thereafter it falls and the count becomes normal. Some patients have recovered from this type of therapy only to relapse and to be nonrespondent to this drug in a future attack.

*Bone Marrow Extract:* Griffin and Watkins<sup>21</sup> of Mayo Clinic have been using extract of yellow bone marrow with good results. A dosage recommended is 20-30 grams daily throughout the acute stages. This represents 100 capsules a day. Marberg and Wiles<sup>22</sup> in 1937 reported cases treated with a yellow bone marrow free from large amounts of fat,

with very good results. This type of therapy produces a response in 24 - 48 hours, whereas pentnucleotide therapy takes from four to five days. The yellow bone marrow is given orally and does not produce the severe, painful reactions either locally or generally that pentnucleotide does.

These last two types of therapy seem to offer our best hope.

*General:* Fluids should be forced in very large amounts,—as much as five to six quarts daily, especially in those cases where drugs seem to have played some part in the production of this disease. Adequate nourishment and general hygiene are, of course, necessary.

#### PREVENTION

The first time the drugs containing the benzene ring are administered to a patient, the white blood count and differential should be checked within 24 hours, and in those cases in which large amounts are used, the white blood count should be checked every other day. However, Young<sup>1</sup> in his case showed no change or warning in spite of repeated white blood counts. This precaution is also applicable in cases receiving antiluetic therapy, i. e., repeated blood counts at frequent intervals may show impending danger. All known drugs and treatment that have been shown in the past to bear some etiological relationship to agranulocytosis should be administered only with frequent studies of the leukocyte system.

#### CASE REPORT

This patient, aged 35, female, white, mother of two children (ages 8 and 12), was first seen on October 22, 1937, with the complaint of frequency and burning on urination and pain in right back for two days.

About two and a half months previously, the patient developed a similar complaint with chills and fever, was treated symptomatically, and a complete urological examination revealed a right pyelitis, from which she recovered. Examination on October 22 was essentially negative with the exception of pain over right kidney. Urine examination revealed a profuse number of pus cells with clumping, and culture revealed a pure growth of *Escherichia acidilactici*. The patient's temperature at this time was 100°. For three days she suffered chills and intermittent fever as high as 107° in spite of fluids and palliative measures. On October 25, she was placed on sulfanilamide, and the next day felt much better. From that time on she was on small doses of this drug, (see chart 1) and her urine remained practically free from pus. The patient felt fine, and even drove to a football game three days previous to the onset of this last illness.

On November 23 the patient phoned and stated that her usual acne was somewhat intensified, and she was told to discontinue all medication. The next day she complained of some swelling under her jaw together with the onset of normal menstrual flow. An examination revealed temperature of 99.2°, pulse 84, a few

#### CHART I

DATE	DAY	DOSE OF SULFANILAMIDE	URINE
Oct. 25th	1	gr. X t. i. d.	About 1,200 pus cells per H.P.F.
Oct. 26th	2	gr. X q. i. d.	About 75 pus cells per H.P.F.
Oct. 27th	3	gr. X q. i. d.	Urine entirely clear
Oct. 28th	4	gr. V q. i. d.	Urine clear
Oct. 29th	5	gr. V t. i. d.	Urine clear
Oct. 30th	6	gr. V b. i. d.	Urine clear
Oct. 31st	7	gr. V daily	Urine clear
Nov. 1st	8	gr. V daily	Urine clear
Nov. 2 & 3	9 10	Discontinued	Urine clear
Nov. 4-10	11 16	gr. V b. i. d.	Urine—15 pus cells H.P.F. Nov. 4
Nov. 11-15	17 to 21	gr. V daily	Urine clear
Nov. 15-18	22 to 25	gr. V every other day	Urine clear
Nov. 18 on	26 on	gr. V every third day	Urine clear
Nov. 23rd	30	Discontinued	Urine clear

With each dose of sulfanilamide gr. v, citrocarbonate Z 1 given.

#### CHART II

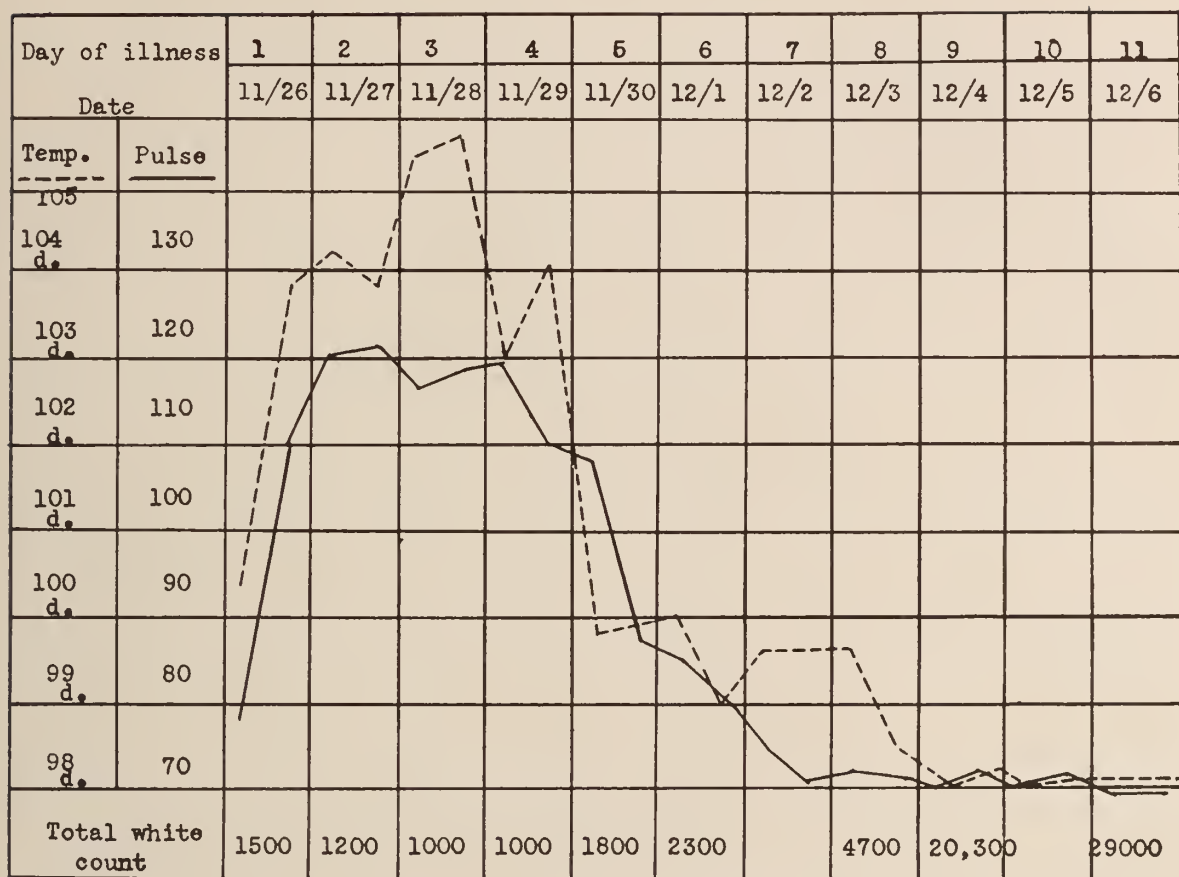
DATE	DAY	TREATMENT	W. B. C. PER CU. MM.
Nov. 26	1	Pentnucleotide— 20 cc. Liver (Campolon) 5 cc.	1,500
Nov. 27	2	Pentnucleotide— 30 cc. Liver ..... 5 cc.	1,200
Nov. 28	3	Pentnucleotide— 35 cc. Liver ..... 5 cc.	1,000
Nov. 29	4	Pentnucleotide— 35 cc. Liver ..... 5 cc. Blood Transfusion—400 cc.	1,000
Nov. 30	5	Pentnucleotide— 35 cc. Liver ..... 5 cc. Bone Marrow 3 Gms.	1,800
Dec. 1	6	Pentnucleotide— 30 cc. Liver ..... 5 cc. Bone Marrow 6 Gms.	2,300
Dec. 2	7	Pentnucleotide— 20 cc.	
Dec. 3	8	Pentnucleotide— 15 cc.	4,700
Dec. 4	9	Bone Marrow 3 Gms.	20,300
Dec. 5	10	Bone Marrow 5 Gms. and daily for 10 days.	

Pentnucleotide, Smith, Kline & French Laboratories, Philadelphia, Pa.

S. E. Marrow, Frederick, Stearns & Company, Detroit, Mich.

Liver—Campolon, Winthrop Chem. Products, New York, N. Y.

C H A R T    I I I



acne form lesions on the face, and a swelling of the submaxillary glands. Other than this, she felt fine, and a tentative diagnosis of submaxillary mumps was made. The next day her left parotid gland was swollen, temperature 100.2° and she complained of a slight soreness of the gums. On November 26, the city epidemiologist confirmed the diagnosis of mumps. However, the extreme prostration of the patient with soreness of gums warranted me to order a blood count, which revealed the blood picture of agranulocytosis.

That afternoon the patient's temperature increased; she was dreadfully ill. She was placed on pentnucleotide, liver therapy, etc. (See chart 2). The next morning for the first time her gums ulcerated in typical fashion, the left ear became swollen and infiltrated, both parotid glands became very tender and more swollen, and the patient was unable to open her mouth to any degree due to this and cervical swelling. As much of the throat as was visible was not ulcerated but deeply congested. She became semi-stuporous and continued in this state until November 30, running a high temperature (Chart 3) and being very sick. On this day the temperature dropped, and patient felt much better, and the blood picture improved. (Chart 4).

From this time, the patient's convalescent period ran very smoothly until December 7 when, for the first time since her previous illness, her urine contained about 50 pus cells per high power field with clumping. Her urine had been examined daily ever since onset of previous condition. Two days later a cystoscopy was done and the examination revealed about 8 pus cells per high power field from the left kidney; the right kidney was normal. The culture showed no growth. A blood culture taken on the third day of the disease

was reported negative. After this cystoscopic examination, her urine became clear, and the patient continued to an uneventful convalescence. With the exception of short wave diathermy being used for the glands of the neck, convalescence was uneventful. The patient is now active, has gained weight and feels fine. I should also mention that previous to her first illness, that is in the early part of 1937, the patient had taken occasional doses of pyramidon, but none since October 22.

Although apparently sulfanilamide played some part in the production of agranulocytosis in this case, it is impossible to state definitely what and how. Young<sup>1</sup> in his case presents a somewhat similar problem and he, too, will not incriminate himself as to a definite statement in this regard. We should not be too hasty in making sulfanilamide the sole culprit without looking further. All in all, there is more than meets the eye in these cases of agranulocytosis.

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CHART IV

DATE AND DAY	TOTAL WHITE COUNT	EOSIN	MYELO-CYTES	JUVE-NILE CELLS	SEG-MENTED CELLS	LYMPHO-CYTES	MONO-CYTES	NUCLEAR INDEX	RED BLOOD COUNT AND PLATELETS Hbg.
11/26 1	1,500					100			60% Hbg. 4,170,000 R. B. C.
11/27 2	1,200					100			Platelets increased
11/28 3	1,000					100			
11/29 4	1,000					100			
11/30 5	1,800			2	8	88	2	4	
12/1 6	2,300			12	12	73	3	1	
12/3 8	4,700	1		18	7	70		.4	
12/4 9	20,300	1		50	27	21	1	.5	
12/6 11	29,000		12.5	53.5	14	19	1	.2	85% Hbg. 4,500,000 R. B. C.
12/9 14	36,900		5	56	25	14		.4	
12/13 17	12,500	1		19	46	34		2.6	
12/17 21	9,200	3		7	47	42	3	6.4	
12/29 33	9,400	5		8	52	32	3	6.5	

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## OBSTETRICAL ODDITIES OCCURRING IN A SINGLE PATIENT

### CASE REPORT

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In almost every doctor's professional experience there is usually one outstanding case that he likes to talk about. In my limited experience I have encountered a patient who presented a series of obstetrical peculiarities that I am sure do not happen often, especially in any individual case. The obstetrical oddities encountered were: a phantom pregnancy, obstetrical mania, and uterine inversion. I believe you will agree that any one of them is rare, and for all of them to happen to the same patient is worth reporting.

The phantom pregnancy and the mania I am not competent to discuss or intelligently give a differential diagnosis of, but I do believe these were true cases and I hope some one will enlighten me on the subjects in the discussion. The etiology of these phenomena is, I believe, conceded to be some neurological condition or syndrome and it will take someone more versed in this field to discuss these conditions and properly correlate the pathological physiology.

Before attempting a discussion on inversion of the uterus, I would like to report the case:

Mrs. S. F. D., white, aged 30, came to me on January 14, 1934, with the complaint of leukorrhea and "female trouble." Her history brought out the fact that August 27, 1930, she had been delivered by a difficult forceps procedure of a stillborn baby that weighed nine pounds. The baby had died during the delivery as she and the doctor were certain it was alive before the delivery. Following this she stayed in bed a long time and remained in a poor state of health. Her history also showed that the loss of this baby almost broke her heart and, to add more burden to her mental state, she had been told by several doctors that she could never have another baby; that she might become pregnant but it would be impossible for her to carry a baby to term due to the condition of her womb; and, in fact, that the womb should be removed.

The thought of not being able to have a baby, the fear of having to have the womb removed, thinking and planning of adopting a child, were taxing her mental powers heavily. In 1932 she did become pregnant but miscarried at four and one-half months. This made her more despondent and the plan to adopt a baby was seriously considered as both she and her husband thought that a child would aid her mental attitude. Before going through with the plans they decided to have me examine her to see if I thought there was a possibility of her giving birth to a baby of her own. She evidently wanted some encouragement and demonstrated this eagerness at all times. The remainder of her personal and family history was essentially nega-

tive, there being no specific diseases in the family. Mental deficiencies and insanity were especially inquired about.

The physical examination presented a well-developed and nourished woman, apparently normal in every respect. There were no peculiarities or abnormalities about her body; her disposition and attitude were apparently those of any normal person. Her conversation was intelligent with no exaggerations expressed that would point to a psychosis. She was normal physically except from a gynecological standpoint. She presented a very relaxed perineum that bore scars from previous lacerations; there was quite a profuse mucopurulent discharge escaping from the vagina. The cervix was in a deplorable condition. It was dilated to about the size of a dollar; there were three large healed lacerations with scar formation and the cervix was firmly adhered to the vagina in such a manner that the introitus was a continuous passage into the uterus almost without obstruction. The cervical portion of the uterus was almost destroyed and differentiating it from the body of the womb was difficult. There was quite a severe endometritis with the endometrium growing out of the cervix. The body of the uterus was freely movable and normal in size. The pathological picture was suspicious of a malignancy; however, this was ruled out by biopsy later on. Blood routine was normal, Kahn negative, and urine negative.

After this examination I, too, told her it was doubtful if she could carry a baby to term but that the chances could be improved by some work on the womb which was necessary for her wellbeing even though she might never have a baby. I explained that as long as she had a womb, regardless of its condition, and a functioning genital system, no one could say for sure that she could not have a baby. Her husband told me later that she said she was going to show these doctors that she could have a baby and she was more determined than ever. At this time she dropped the adoption procedure. Later she came to me for treatment of the womb. After a series of cervical curettages and cauterizations the infection was well in hand and the discharge cleared up. She felt better and her spirits were not so destitute. After discharging her I did not see her again professionally for several months.

On August 14, 1934, she appeared in my office with a very confident smile and said that she was pregnant and was feeling fine. Her last menstrual period was April 20. She had waited until she missed three periods before coming because she wanted to be sure of the pregnancy. I examined her and to my surprise the cervix had retracted to the size of a quarter. It looked healthy but it was still tightly adhered to the vaginal wall. The uterus was slightly enlarged but not enough to be conclusive that a pregnancy existed. She had all the subjective symptoms of early pregnancy such as morning sickness, full and tingling feeling in the breasts, etc. I told her that in all probability she was pregnant and I didn't see why she couldn't carry the baby normally. I was sincere in my statements as I have seen wombs in worse condition go through pregnancy and delivery uneventfully. She was given my routine instructions for obstetrical care.

A month later she came for her checkup, as she had been instructed. She presented all symptoms of a five-month pregnancy and told me she had felt the baby move. With all these symptoms I did not think it necessary to further examine her to determine the existence of pregnancy but considered it a fact and began encouraging her in her endeavor. I began to feel quite proud over my accomplishment. Apparently she had passed the time when she miscarried before, and to escape this misfortune was having its effect upon her. She was indeed very happy and was a pleasant obstetrical patient.

One month later, October 6, she had what I termed a threatened abortion. She had to remain in bed for several days and sedatives were given to prevent the uterine contractions from progressing. There was no other symptom of a miscarriage. The next two months



she came in at the usual time for her checkup, and was apparently progressing satisfactorily. She was looking the part of advanced pregnancy, and by this time I considered the case "in the bag" with only the delivery as a problem.

January 27, 1935, was her expectant date of confinement and on January 25 she came in to see me. On glancing at her I told her that she apparently was not going to have a very large baby and that this was perhaps the reason she had gone through so well. With a worried expression she said that she had not felt the baby move in several days and wanted me to see if something was wrong. Upon examining her I was amazed to find her enlarged abdomen very soft and no fundus uteri to be felt. Her vertebrae were easily felt through the soft and boggy abdomen. I examined her pelvis and found the uterus just as it was when I first examined her in the supposedly early pregnancy. All I could do was to tell her the facts and try to explain just what the condition was. At first she took it pleasantly and considered it a big joke, a joke on me as much as on her. Then she became hysterical but she conquered the hysteria and became composed before she left the office. She told her husband about it and instead of becoming melancholy she was enraged and emphasized her determination to yet have a baby. After three weeks her abdomen had completely gone down and she was again normal in figure. She resumed her menstrual periods and they were quite regular for several months afterward. Apparently she was in better health than she had been for several years. I did not see her again for some time.

On May 22, 1936, she came into my office and announced that though she was not so sure this time, she believed she was really pregnant, her last menstrual period being December 25. She had waited to come to me until she had missed four periods and it was now time for the fifth. She was at this time in very good spirits and made several joking remarks about the past experience. She had all the symptoms of pregnancy and upon examining her a diagnosis of pregnancy was made and the duration set at about four and one-half to five months. She progressed normally but on August 25 she came to me complaining that she was very nervous and couldn't sleep at night. I checked her carefully and found her functioning normally, presenting no evidence of being toxic. I prescribed amyltal tablets, grains  $1\frac{1}{2}$ , taken as necessary to produce sleep. Her attitude at this time had changed from the happy disposition to a more serious and melancholy one. I noticed a peculiar stare in her eyes and that she wanted to look out of the window constantly. She did not take the lead in conversation, only talked when questioned, but seemed to answer normally.

Around September 5, she became completely deranged mentally, talking and acting in a peculiar manner. This developed into more pronounced signs and symptoms. Her hallucinations were seeing and hearing things that were not real. She walked a great deal and talked to herself. This continued until September 28 when she became quiet and assumed a catatonic attitude. She wouldn't talk at all and acted asleep though her eyes were not closed. She apparently slept normally at times. She would remain in the same position for hours and hours. Her reflexes apparently were normal, but she would not respond to the prick of a pin anywhere. She did not present any evidence of toxemia. During the time she was mentally deranged she would eat but little food and even though the pregnancy progressed she lost a little weight all the time. The evening of the day on which she assumed this catatonic attitude she presented facial expressions as though in pain. I went to see her and when she would present these facies the uterus would be contracting. I watched this for some time, decided she was in labor, and took her to the hospital. Her expectant date was October 2, and as this was September 28 I thought she would deliver. The next day her attitude changed, she slept a good deal and the uterine contractions ceased. I sent her home. She remained in this state until October 7, a little after midnight, when she went into real labor, com-

plaining of the pains when they came but otherwise she would not talk or move.

At 7:20 that morning she delivered a baby girl, spontaneously, without any form of anesthetic. The baby was small, weighing five pounds, weak, cried feebly, but came around fine although it remained delicate and would not take much food. It progressed very slowly and at the age of four months died of bronchopneumonia. The mother never showed any sign that she was aware of having a baby and when the child was placed in her lap she looked at it as though it was something she had never seen before. About a month after the baby died the mother began to clear up mentally, and in about another month she was apparently back to normal. She did not remember having the baby. She could remember having been pregnant and thought she remembered a baby dying, but did not remember it was hers. She resumed her housekeeping duties and her husband said she was normal as far as he could tell.

On August 25, 1937, she came to me and said she thought she might be pregnant, even though she had been advised by me to avoid pregnancy. She was at this time suffering extreme nausea and vomiting and had missed one menstrual period. She would not permit an abortion or even talk about it. I put her on suprarenal cortex preparation to which her nausea and vomiting responded. I did not examine her for pregnancy except to take her blood pressure and make a urinalysis. I gave her a month to decide if she wanted to run the risk again and she elected to do so. I began giving her big doses of vitamin B<sub>1</sub> (Hepi-colum compound—Lilly), and pushed her diet and activity to the best of my knowledge. Blood, spinal fluid and Kahn were negative. No gold curve was run. A secondary anemia was corrected with liver and iron preparations.

Her expectant date of confinement was March 15, 1938. She progressed normally and had no trouble prenatally. On February 15 her membranes ruptured spontaneously. She was brought to the clinic and a breech presentation was easily converted into a cephalic by external podalic version. She did not go into active labor for twenty-four hours and was sent home. On February 20, four days later, she went into very active labor. The contractions were hard and very forceful and lasted two to three minutes each with only two or three minutes between pains. She was quickly returned to the clinic and within three hours delivered spontaneously, without any anesthetic, a very well-developed and nourished baby girl, cephalic presentation and left occipito-anterior position. The placenta delivered spontaneously with the next pain. These pains resembled those following an oxytocic but no oxytocic was given her at all.

I was delighted that she had come through so nicely and was taking care of the baby routine when I noticed she was very pale and apparently asleep. There was no excess bleeding but I did notice there was something presenting itself at the introitus and I found it to be the endometrium of the uterus. Her pulse was weak, feeble and fast. She was immediately put into extreme Trendelenburg position. With my left hand in a cup-like position I quickly worked the inverted fundus back past the cervical ring and then closed my hand and with my fist pushed the fundus as far up into the abdomen as I could. I held it in this position until my nurse could give the patient 1 cc. of adrenalin and cover her with blankets. Soon I felt the uterus contract about my hand, wrist, and forearm. After the second such contraction I removed my hand, as there was some hemorrhage from the trauma of the uterus, and packed the uterus and vagina tightly with sterile gauze. About this time the patient recovered from the shock but I kept her in this position for several hours. After about three hours I began removing the pack, a little at a time, and after five hours it was all removed without any resultant bleeding.

The patient made an uneventful recovery and today is a happy and devoted wife and mother. She seems to be physiologically normal in every respect. Her cervico-vaginal relations are greatly improved over my first



findings. The process of having two children, the traumatic manipulation of the cervix, and the complication of the last delivery have no doubt accidentally improved these relations. The cervix at the six weeks' checkup was still open to about the size of a quarter, but did not present any lacerations.

Those of you who have handled a uterine inversion or who have read the literature on the subject will readily realize that the condition is extremely rare. I have been fortunate enough to have dealt with two cases, one when I was an intern at Tulsa, Oklahoma, and the one which I have reported. The latest figures quoted by Findley state that the phenomenon occurs once in 113,068 deliveries, while at Boston Lying-in Hospital, inversion has occurred once in 7,837 deliveries. Maxwell, at the University of California Hospital, reports the frequency as one in 6,500 deliveries. I am convinced that it occurs more frequently than this due to the fact that many cases occur in the hands of general men and are never reported; the statistics come only from hospital deliveries. Undoubtedly, many inversions are not recognized and correct themselves spontaneously. This is especially true of incomplete inversion where the fundus only dimples itself and does not pass the cervical ring. Many patients suffer hemorrhage and shock from inversions thought due to something else, and oxytocics are given with no avail, aggravating the condition and resulting fatally. The death certificate shows postpartum hemorrhage with cause unknown, uterine inertia, or retained secundae. If all of these cases could be scientifically and skillfully handled, investigation would probably reveal that inversion of the uterus is more common than is known today.

The etiology has never been clinched but a number of theories are prevalent which have their merits. The most common cause is conceded to be due to pulling on the cord too hard with the placenta still attached to the fundus and too severely executing the well known Crede method of placental delivery. Some authorities do not recognize these factors as the true cause. They claim that a uterus normal in anatomy and not physiologically fatigued would not invert under these conditions and claim the true cause to be a weakness of the underlying musculature and its failure to contract with the placenta still attached. They say the weight of the

placenta indents the fundus and the uterus tries to expel it as it would a foreign body, this being true of improper Crede maneuver. Fibroids in the fundus pulling down on the uterine wall is also given as a frequent cause. The most common symptom of this condition is hemorrhage and shock. Fifty per cent occur in primipara, the cause not being known.

Treatment is still undergoing change as there have not been enough cases reported from which to draw any definite conclusions. I think common sense, plus a mechanical knowledge of the anatomy and physiology of parturition are the essential factors, as acute inversion is nearly always complete unless recognized immediately and corrected. As in other grave acute conditions the first thing to do is to institute measures to control hemorrhage and shock once the condition is apparent. One authority advocates immediate laparotomy as soon as the shock is controlled, a blood transfusion if there is much hemorrhage, and the inverted fundus drawn back into its normal position with Allis forceps. Once back, it will stay. Others advocate reposition of the fundus from within. If the placenta is still attached, some detach it before reposition is attempted as it is easier to accomplish; others advocate the opposite. To correct the condition from within is somewhat like my procedure though more expertly and skillfully performed. However, one does not have much time to think as the condition is alarming. The prognosis is good under suitable surroundings, but grave when it occurs in the home. When it occurs in the home, measures to combat shock should be instituted immediately: the vagina should be packed tightly to control hemorrhage; and the patient rushed to the hospital. If the condition is allowed to remain uncorrected too long, the patient will die from gangrene of the fundus, if not from hemorrhage and shock, as the circulation is cut off by the contracting cervical portion of the uterus. If gangrene is apparent perhaps hysterectomy is the treatment of choice.

In my case, I believe the inversion was due to the cervical portion of the uterus being attached to the vaginal wall, preventing the fibers from contracting in proportion to those of the fundus, the contractions being forcefully followed by the detachment of the pla-

centa before it was complete. However, this inversion was not fully complete as I believe I restored it before such was the case. Perhaps it would have corrected itself in extreme Trendelenburg position, but having had one other experience, I did as I was shown then. The fact that the placenta was detached and expelled quickly prevented a severe hemorrhage, the only bleeding being due to trauma of the uterus which the uterine pack controlled.

## TREATMENT OF TRAUMATISMS OF THE CHEST

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Since the time of Vesalius, injuries to the chest wall and its enclosed viscera have been of interest to the physician—principally because of the physical and anatomical considerations involved in the aerated lung and its surrounding area of negative pressure as well as because of the vital contents of the mediastinum. The increase in industrial hazards and automobile accidents of the present day has made these injuries of common rather than unusual occurrence. The most frequent wounds in civil life are the crushing injuries following auto accidents and gunshot or stab wounds. The large sucking wounds of war-times are less frequently seen.

A discussion of such traumatic conditions of the thorax is, of necessity, based on the degree of involvement by the injury of those anatomical structures and may be divided into four large groups: 1. those injuries producing contusions only; 2. those producing so-called traumatic asphyxia; 3. fractures of the bony cage; and 4. injury to the pleura or thoracic viscera by closed or open wounds.

### CONTUSIONS

Blows with blunt objects or crushing injuries of moderate severity result in contusions accompanied by local discoloration, pain, and lameness. The extent of injury and period of disability are determined largely by the elasticity of the chest wall which in turn is dependent chiefly upon the age of the patient. Subcutaneous or subperiosteal hematomas

may occur but require no special treatment. With no other complicating injury, treatment consists chiefly of rest, strapping, heat, and analgesic measures to control pain. Pneumonia or pleuritis may develop and the presence of clear fluid in the chest should always bring to mind the possibility of reactivation of a tuberculous process. The prevention of pneumonia and atelectasis is best accomplished by the judicious use of sedatives in amounts sufficient to control pain without depressing respiration.

### TRAUMATIC ASPHYXIA

Homans<sup>1</sup> points out that severe prolonged crushing of either thorax or abdomen, such as is inflicted by crowds, beams, compression between trucks and buildings, etc., may, if not immediately fatal, produce asphyxia with bluish-black discoloration of the face, neck, and thorax. There is no subcutaneous edema except for minute areas of ecchymosis. The cyanosis appears in from a few minutes to several hours, becomes progressively more pronounced, and as a rule persists from 2 to 4 days.

If there is immediate survival, the prognosis is usually good, although retinal edema and hemorrhage occasionally result in optic atrophy and blindness. Such traumatic cyanosis is due to the marked venous engorgement of the head and neck resulting from the paucity and incompetence of the valves of the great veins in this area. Treatment is directed to any complicating injury to chest wall or thoracic viscera, bed rest in the semi-recumbent position with the relief of pressure being all that is required to overcome the results of the temporary anoxemia.

### FRACTURED RIBS OR STERNUM

Fractured ribs are of rather common occurrence as the result of a direct blow or sudden muscular effort. In the majority of instances such injuries are uncomplicated and require no other treatment than rest, symptomatic control and relief of pain, and immobilization by strapping. Perforation of the lung or pleura or coincident deep contusion of the lungs and mediastinal structure are, however, to be carefully excluded in each such case. The treatment of these will be considered later.

Fractures of the sternum usually occur in the manubrium as a result of football injuries or other direct blows, are usually controlled

<sup>1</sup>Read before the Nineteenth Annual Meeting of the Florida Railway Surgeons Assn., Miami, May 9, 1938.



by hyperextension and bed rest with sedatives, but may rarely be accompanied by such a degree of overriding and compression as to require elevation surgically. Rupture of the trachea which occasionally accompanies these injuries necessitates tracheotomy.

#### INJURY TO PLEURA AND THORACIC VISCERA

a. *Closed Wounds:* These include all wounds which leave the chest wall intact. Severe contusions may produce direct injury to the pleura, heart, mediastinum, or the intrathoracic vascular tree and, without any external communication, produce pneumothorax, hemothorax, or any of their attending complications. In such instances pneumothorax is generally due to a ball valve mechanism in the ruptured alveolar tissue which produces an internal pneumothorax, allowing air to enter but not to leave the pleura, effecting a collapse of the lung and a shift of the mediastinum to the opposite side. Extreme dyspnea occurs and death by asphyxia may result from the so-called "pendle luft" of the German writers, that is, the large "dead space" produced by expired air from the good lung entering and returning from the affected side with respiration.

Hemothorax in these instances is usually the result of tearing old adhesions by the advent of air, or trauma, or the direct injury to the vascular tree by the trauma and, as such, may be due to ruptured intercostal, internal mammary, bronchial, or pulmonary vessels. The first two of these often require ligature which can usually be accomplished without excessive difficulty. In the event that the bleeding is from the pulmonary vessels at the lung periphery, the blood and air in the pleural space are usually enough in themselves to effectively tamponade these vessels whose pressure is low and easily overcome. Intravenous therapy may be effective and is safely used to combat the falling pressure, blood loss, and mild shock often present in these cases.

If a good sized bronchial artery is ruptured, however, the problem is more serious. The intra-arterial pressure in this case is high. The alveoli and bronchi fill with blood, which may appear in the sputum, and intravenous fluids will serve only to heighten the blood pressure and increase hemorrhage. If bleeding does continue and shock is severe, aspiration of the

pleural fluid and replacement with air and autotransfusion may be resorted to. The only alternative in severe cases is immediate lobectomy, but the mortality of such cases is almost prohibitive.

In the past, the treatment of the more usual, less severe instances of hemothorax and hemo-pneumothorax from chest injuries has been aspiration after a period of 3 to 4 days and the replacement of the fluid by air. The purposes were to reduce infection in the culture media provided by the old blood, to immobilize the lung and compress the wound, and to prevent formation of adhesions, while at the same time allowing the unaffected lung free expansion. However, more recently, Elkins,<sup>2</sup> in his series, has obtained equally good results with more conservative measures and uses thoracentesis only for the relief of pain or dyspnea when the compression of the lung is too great. Infection of the pleura in the form of empyema or infected hemothorax occurred in only 1.4 per cent of all his cases, a remarkably low and encouraging figure. It is important that the air injected in those cases in which aspiration is necessary be well filtered, and our method of procedure is to draw the air through a solution of merthiolate.

Fractured ribs or sternum with penetration of the thoracic viscera by the fragments are among the most serious of all closed wounds of the chest. These may be relatively mild in nature, as in the case of the production of a simple pneumothorax, or very severe, as in those instances where the entire chest is crushed causing rupture of the pleura, lungs, mediastinum, and even the pericardium and heart. Symptoms naturally vary in intensity with the extent of the injury, but the patient may be in an extreme degree of shock due to marked loss of blood, bilateral pneumothorax and the effect of trauma.

Berry<sup>3</sup> in his recent review of such wounds outlines the following regime to be used in the treatment of such cases:

1. Elevation of the head of the bed to the maximum comfort of the patient.
2. Relief of pneumothorax or hemothorax, unilateral or bilateral, by careful aspiration or by a water-sealed catheter system.
3. Sedation to allay pain, preferably small frequent doses of opiates which will accom-



plish this without depressing respiration. Support and immobilization of the chest by sandbags or a binder is likewise of value in reducing the natural splinting process.

4. Maintenance of an atmosphere of high oxygen content either by an oxygen tent or by nasopharyngeal administration of oxygen.

5. The judicious and early use of transfusion to combat shock and acapnea resulting from shallow respirations and the washing out of carbon dioxide.

6. The elevation, if necessary, of a depressed manubrium which is producing obstruction.

In all hands and with every available form of treatment, however, the mortality rate among cases of such extensive injury is high and the incidence of pneumonia great. Interstitial emphysema is of frequent occurrence with rupture of the lung and is usually neither severe nor prolonged but may rarely require supraclavicular incisions for its control.

Contusions of the heart are rather frequently seen in injuries from car accidents and may be immediately fatal if rupture of this organ takes place. If not, the symptoms are those of precordial pain, dyspnea, cyanosis, tachycardia, and arrhythmia. Therapy in such instances is chiefly symptomatic, but complete bed rest with adequate sedation is essential. The extent of the damage is best determined by the careful observation and electrocardiographic studies of a capable internist. The use of digitalis is of doubtful value.

Traumatic mediastinal hemorrhage has been reviewed by Zimmerman<sup>4</sup> and is best treated expectantly with rest and sedation and observed over a long period for late sequelae such as mediastinitis.

b. *Open Wounds*: These are most frequently hand-inflicted, the common weapons being either knives or ice picks. Thus, Elkins<sup>2</sup> found that of 553 patients with penetrating chest wounds, 354 had been produced by knives and 93 by ice picks, and Steward<sup>5</sup> found 190 of 240 wounds hand-inflicted.

The small puncture wounds caused by ice picks and like instruments are similar in effect and management to the closed wounds of the thoracic viscera described above. The external wound closes rapidly and efficiently. Debridement and cleansing of the external

wound and the routine administration of tetanus antitoxin is, of course, imperative. In spite of the general conception to the contrary, the incidence of suppurative infection as a result of the introduction of the foreign material is low. Management of these cases is similar to that of like conditions with closed wounds, that is, rest, immobilization, sedatives, oxygen, hemostasis, and aspiration in selected cases of pneumothorax. Blood in the pleural cavity is usually aspirated and replaced by air after the third day.

We have been particularly impressed by the relatively long latent interval following the relief of initial symptoms before the appearance of such occasional sequelae as pneumonitis and mediastinitis. During this interval the incautious or uninformed patient is prone to initiate or aggravate the development of such sequelae by excessive activity and the lack of moderate precaution.

In all instances of penetrating wounds accompanied by shock, it is again emphasized that the differentiation must be made between those cases in which pneumothorax is a minor incident and those in which collapse is due to cardiac embarrassment from lung compression with resultant severe mediastinal displacement. This is of utmost importance because in the latter group intravenous fluids will serve only to increase the burden on the right heart and, consequently, heighten cardiac embarrassment.

In large, gaping wounds of the chest wall the immediate problem varies somewhat from that in small wounds. Since the opening is larger than the laryngeal orifice, air enters the chest most readily through the wound and the lung rapidly compresses, expanding slightly with expiration and collapsing with inspiration. With this there is the so-called mediastinal flutter, the whole mediastinum moving away from the injured side with inspiration and conversely with expiration. The clinical picture is that of extreme anxiety, air hunger, shock, and, finally, asphyxia from the useless exchange of air between the two lungs. The immediate closure of the opening with whatever clean material is at hand and the earliest possible debridement and suturing of the pleural and superficial tissues are essential. Hemostasis is an essential less easy to effect

at times but usually eventually accomplished. The removal of foreign bodies from the lung at this time is not recommended unless they are very readily accessible. Once the chest wall is closed and immediate shock and asphyxia combatted, treatment is the same as described for open wounds made by smaller objects.

Penetrating wounds of the heart and pericardium, as a rule, result in the sudden death of the patient from hemorrhage. However, occasionally, especially if it is the ventricular muscle that has been pierced, the distention of the pericardium with blood may serve as an effective tamponade. Absence of pulsation of the cardiac shadow on fluoroscopic examination is indicative of this condition. The patient's condition is, of course, critical and immediate surgery is indicated with the removal of several ribs to expose a field through which the pericardium may be evacuated and the cardiac muscle sutured. Sutures are of silk and the apex is held with a guy suture during the operation. Infections are frequent and the strictest asepsis is to be observed, but with proper management such injuries are no longer as fatal as they were once considered.

Mortality figures of all thoracic injuries handled by such means as are outlined above are remarkably low. In Stephens' 162 cases the mortality rate was 9.5 per cent and in Elkins' 400 cases, 7 per cent.

In summation, it is to be observed that with the present concepts of treatment, with early diagnosis, proper facilities, and the anticipation of complicating sequelae, the results of treatment of traumatism of the chest are no longer to be regarded with the same dismay as formerly but are definitely encouraging.

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## CARDIOLOGY IN AVIATION

### The Cardiac Patient and Air Travel

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The interest of the general practitioner in aviation medicine is daily becoming more apparent with the development of commercial aviation. There are great opportunities and a greater future in air travel, and the medical profession must keep abreast of the progress and aid in its development.

More and more of the general practitioners, particularly in the larger cities of Florida, are being asked by their patients, "Doctor, is it all right for me to fly?" As time goes on this question will be asked frequently because air travel is constantly on the increase. Florida, at present, has several air terminals. With new airlines having been given franchises into Florida from different Northern points, with the general public realizing that travel by air is being done daily, safely and swiftly and in complete comfort, we are constantly seeing an increasing number of visitors utilizing this mode of travel.

Many people coming to Florida are individuals who have cardiac defects from various causes. In daily practice, the general practitioner sees a large number of "heart cases" who come to him for advice as to their regimen of living, treatment, etc. From personal experience, just within the past months, the decision as to whether certain individuals with heart disease should travel by air, has been left to the doctor. In reaching this decision there was little precedent to follow because, heretofore, the physical condition of the pilot has been the primary consideration, with little or no regard to that of the passenger.

The factors involved in the discussion regarding heart disease and air travel would include: primarily, the condition of the patient; and then the effects of different situations encountered in flight, including altitude, speed, climatic conditions, emotional stress, etc. Regarding altitude, McFarland and Edwards' recently, in an investigation concerning the effects of prolonged exposure to altitude during a Trans-Pacific flight, determined that both airmen and passengers maintained a high degree of neurocirculatory efficiency



based on the Schneider index. (The Schneider index test which is frequently mentioned in examinations, is a performance test for cardiovascular fitness.<sup>2</sup> This test evaluates the results from six sets of observations of pulse rate and blood pressure under differing conditions, and the index rating is computed by means of a table of arbitrary scoring in which the values vary from minus 11 to plus 18. In the healthy adult male, the average figure has been found to be between plus 7 and plus 13. Schneider believes that a score of plus 7 or less, is an indication of improper functioning of the neurocirculatory apparatus.)

McFarland and Edwards found that there is an initial response to altitude which results in an increase in pulse rate and an increase in systolic blood pressure, which is followed by a well-controlled fall to normal values if the subject remains at rest. There appeared to be a general tendency toward low blood pressure as the flight progressed, similar to that observed in acclimatized workmen at high altitude in the Andes. They found that there was a consistent decrease in the Schneider scores which was related to the increased pulse rate in regions of high humidity and high temperature. They found further that there was an increase of approximately 10 per cent in the red blood cells at high altitude. This count returned to a more normal value at sea level in five to six days. The normal non-protein nitrogen, blood sugar, and cholesterol values indicated that there was no serious upset of the protein, carbohydrates, or fat metabolism of these airmen. The normal value of the blood sugar suggested that there was no intense emotional excitement or increased secretion of the adrenalin while in flight. In general, they reached the conclusion that passengers, as well as airmen, become acclimatized to the high altitude, and show no objective signs of fatigue or physical distress. Their work was carried on at an altitude averaging 9,460 feet.

The question of a passenger with heart disease is purely one of altitude, according to Doctor Bauer in a discussion of an article by Wurdemann.<sup>3,4</sup> He states: "A passenger with heart disease is not any more apt to develop an attack in the air than he is on the ground, unless he goes to an exceedingly high altitude. In fact, if I had a patient that I wanted to send from New York to some place in the

West or on the Pacific coast, I would rather have him transported by airplane than any other way, because I think there is less shock to it."

The tendency to fly at great elevations makes the bodily changes, attributed to altitude in the cardiac type, of increasing importance. There have been a number of deaths among air travelers which have not been related to aircraft accidents. Some of these deaths have been thought to have been due to anoxemia upon an already damaged heart, but the explanations are not adequate because of the uncertainties involving the subject of collapse and death at high altitudes.

An informative and interesting article has been published by Dr. Lewis Bishop, Jr.<sup>5</sup> In his discussion, "Is it safe for the Heart Patient to Fly?", he first considered what studies have been made and what the effect of altitude is on the heart. Investigations carried on as far back as the World War have apparently proved that when collapse occurs at high altitude, cardiac dilatation does not take place. Certain physiological facts have been demonstrated by the work of Schneider and Lutz.<sup>6</sup> They state that: "The heart rate responds to slight changes in oxygen tension, with an increase in rate in the majority of individuals; the diastolic pressure usually falls, the systolic pressure remains the same, and the pulse pressure usually increases."

Recently cardiac patients were subjects of experimental work carried on at Harvard University regarding induced asphyxiation with special reference to certain hazards in air traffic. In this work, thirteen cardiac patients and a like number of normal individuals were subjected to an oxygen tension which would correspond to an elevation of 14,500 feet. Included among the patients were subjects with hypertensive heart disease, coronary heart disease, and rheumatic disease. The most striking feature of the test was the absence of complaint on the part of any subject, despite the fact that three of the thirteen patients fainted, and that four others exhibited signs of cardiac embarrassment. The conclusion is that many cardiac patients are in danger when the oxygen of inspired air falls to 12 per cent, which would correspond to an elevation of 14,500 feet. The untoward effects observed may have been due to the general unfitness which is so often associ-



ated with heart disease or more directly to the embarrassment of the heart itself.<sup>7</sup>

Beyne<sup>9</sup> states that up to a certain degree the body adapts itself to variations in atmospheric pressure, after which the quantity of oxygen absorbed per minute falls below the requirement of the organism. If the tension of oxygen does not fall below 11 per cent, pulmonary ventilation and respiratory quotient remain normal. Levels below the above result in dyspnea and periodic respiration. The altitude at which this occurs may be as low as 10,500 feet for some individuals, especially during muscular exertion. Against this relative asphyxia, the body summons various defense mechanisms, i. e., the number of red corpuscles is increased and the pulmonary ventilation is increased. In a low atmospheric pressure the human organism suffers a relative anoxemia, due not to deficiency of oxygen, but to insufficient tension of this gas. A number of disorders have been attributed to sudden variations in atmospheric pressure, the severity of which are in direct proportion to the rate of variation. These disturbances have been noted both in rapid ascents and rapid descents. They consist chiefly in an acceleration of the heart rate and in variation on arterial blood pressure. The cardiac rhythm and arterial pressure tend to return to normal as soon as the variation in atmospheric pressure ceases.<sup>8</sup> Beyne concludes that the real effect of variations in atmospheric pressure is hypertensive, increasing with the rate of diminution of pressure up to a certain limit. The effect of low oxygen tension, if sufficiently accentuated, is hypertensive.<sup>9</sup>

Atmer,<sup>10</sup> describes reactions in various tests concerned with altitude. Symptoms of marked psychic excitement were characterized by tremor, pallor, fall in blood pressure, and threatened collapse.

An ascent to high altitudes, in Holmquist's<sup>11</sup> opinion, causes an immediate change in blood composition, so that after three hours there is a rise in the adrenalin content of the blood. The blood sugar rises about 33 per cent. The plasma calcium falls about 26 per cent. A fall in barometric pressure causes increased tonus of the sympathetic nervous system, with increased adrenalin secretion and increased blood sugar, and a fall in the calcium content. Schwarz<sup>12</sup> found that atmospheric pressure exerts no effect on lung volume. Jongblood<sup>13</sup>

recommends that passengers should be protected against difficulties encountered at 15,000 feet altitude. He recommends that passengers should inhale oxygen and preferably the pilot also. He further states that it should be admitted through a ventilating apparatus into the cabin, as masks may terrify the passengers and may be difficult to adjust.

The effects of climatic conditions, changes in temperature, etc., do not have to be considered in detail, because modern air travel is conducted under favorable conditions as a rule. Passenger planes at present have adequate heating and ventilating arrangements. Cold may cause painful sensations leading to nervous fatigue and loss of energy, and likewise cause vasomotor reactions which may disturb the circulation of the blood in various ways.<sup>8</sup>

Disturbances have been described as due to variations in speed. They may be attributed to certain phenomena of inhibition or circulatory disturbances, occurring during abrupt changes in speed. They manifest themselves chiefly by a sensation of congestion of the face and head, cerebral vacuum, painful impressions of displacement, actual pain in the abdominal organs, sudden loss of self control (especially during spins), and sudden transitory inhibition of voluntary movements. Sudden variations in speed cause what Flamme designates as "aerial shock" because of their effect on the thoraco-abdominal organs, whose anatomic disposition renders them incapable of adjusting to sudden changes in force, exceeding resistance of their own weight. They tend to dislocate with traction on nerve plexuses and mesenteries. Experiments have shown that sudden changes in speed cause bradycardia and a fall in arterial blood pressure. Broca has shown that centrifugal force may cause cerebral anemia. Flamme believes that in brutal loops, this force may check the cerebral circulation.<sup>8</sup>

Emotional stress is also to be considered in this subject dealing with heart patients and air travel. Bishop<sup>6</sup> brings out the type of individual with whom we will have to deal in stating whether it will be safe to fly as a passenger. He is usually in middle life, often with hypertension or with some degree of coronary sclerosis, with or without anginal pain, who may use flying in his business or is interested in it as a means of pleasurable travel. Conditions of flying ordinarily en-

countered are such that there is no cause for emotional stress in the average individual. The passenger sits quietly and there is no fear of falling because there is no sensation of height or altitude as such. There is no noticeable lack of oxygen unless an altitude of 10,000 or 12,000 feet is exceeded for a considerable length of time.<sup>5</sup> Cardiac patients with associated anxiety, hypochondriasis, or hysteria require special consideration unless they are accustomed to flying.

The question of how to advise heart patients is rather a difficult one. Recently, the author was asked by a patient with hypertensive heart disease and with a history of angina pectoris, as to the advisability of traveling by air from Florida to Chicago. The patient appeared to be well compensated and he had not had any recent anginal attacks. The author, having made this trip several times in the past by air as well as by automobile and train, advised the patient that, in his opinion, there would be much less risk in traveling by air than by automobile, as the patient usually did. Two days elapsed, and during the night prior to the day of leaving, he was awakened with a coronary attack. He died within a few hours. If this man had died while enroute by plane, the mode of travel would undoubtedly have been considered the contributing factor.

Doctor Greene, in a personal communication, wrote: "It is a conclusion that if the cardiac patient is ambulatory and well enough to handle his simple affairs on the ground, he can fly without danger at the altitudes now reached in routine airline operation." Doctor Greene further states: "The writer is the victim of a severe coronary occlusion. Lengthy automobile rides have proved to be quite exhausting in my case. Traveling by train is, to a less degree exhausting. In connection with my official duties, I fly far and wide, and have at times piloted small planes and have thus far suffered no ill effects."

#### SUMMARY AND CONCLUSIONS

1. The subject of the cardiac patient and air travel is of increasing importance to the general practitioner because of the growing use of this mode of transportation.

2. Considerations involved in this subject include discussions of the effects of different situations as encountered in flight.

3. Altitude is of great importance because of disorders attributed to changes in atmospheric pressure.

4. Disturbances resulting from speed occur chiefly as consequences of abrupt variations.

5. Emotional stress must be considered, as any form of excitement is unwise for the majority of heart patients.

6. The man who has cardiac disease but who is able to be moderately active without indications of distress, may be advised to travel by air.

7. The cardiac patient who is accustomed to flying and who has a philosophic attitude toward his condition is as safe on a plane as he is on a train. Without question he is more safe than if he travels by automobile.

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# Daytona Beach, The Convention City



BEACH STREET, FACING THE HALIFAX RIVER. ONE OF THE PRETTIEST SHOPPING DISTRICTS IN THE WORLD

## DAYTONA BEACH, THE CONVENTION CITY

Daytona Beach will be entering upon the best month of the year in that east coast resort when members of the Florida Medical Association and their guests meet there at the beginning of May for their annual convention. For May finds Daytona Beach in the full glow and fragrant color of Spring without the heat of summer, the days and nights usually clear, the sea breeze balmy, the air fresh and exhilarating. Nearly all the winter residents

and visitors will have returned home, leaving the city's facilities for recreation and enjoyable leisure at the full disposal of those attending the convention.

Physicians who have just heaved a sigh of relief over the end of a heavy winter or arduous work and interminable hours of responsibility will heave even a greater sigh of relief when they arrive in Daytona Beach for the annual meeting, for no matter how attentive they may be to the business of the convention there will be ample opportunity for periods of quiet and rest, and the city offers many and



FEEDING GULLS ON THE BEACH



varied facilities for outdoor and indoor recreation and amusement.

Golfing, surf bathing, tennis, fishing, trapshooting are among the outdoor sports to which visitors will have easy access with all the accommodations afforded at the height of the winter season, for Daytona Beach is an all-year resort and what it has to offer the visitor is available 12 months in the year.

There are five golf courses within the environs of the city, and they will be at the top of their condition when the convention opens.

Tennis courts, well groomed and with attendants ready to take care of every demand of the casual patron will be found within a few moment's walk of the headquarters hotel.

Daytona Beach's famous seashore is noted as one of the finest and safest bathing beaches in the world, and it will be at its best in May. Lifeguards will be on duty through the day. Motoring on this beach, especially early in the morning and in the early evening, affords a pleasure that can be enjoyed but few places in the world, an unexcelled mode of utter relaxation in a short time.

There are a dozen or more places and ways of going fishing in Daytona Beach, and May

is one of the best months of the year for this sport in and near the city. Special arrangements have been made for a fishing trip or two during the convention, but there will be ample opportunities besides for casual excursions with rod and reel. Only a short distance from the hotels on the beach side of the city is the ocean pier, reaching 1,250 feet into the ocean—a splendid spot for fishing before breakfast or dinner. Trout, bluefish and other small game fish are caught by the thousands from this pier.

Surf casting is another sport that can be enjoyed at Daytona Beach with the time element required for the sport reduced to the lowest possible minimum. Boats are available for excursions down the river or into the open sea.

Daytona Beach Gun Club is rated the finest club for straight trapshooting and skeet in the entire south. The superintendent in charge will be ready to accommodate visiting shooters.

Excellent restaurants, smart dine and dance places and cocktail bars, good theaters will help to make the stay of those attending the convention comfortable and pleasurable.



BOARDWALK SHOWING THE LARGEST BAND SHELL IN THE WORLD

# PROGRAM

of the

## SIXTY-SIXTH ANNUAL MEETING

of the

### FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD AT DAYTONA BEACH, FLORIDA

MAY 1, 2 and 3, 1939

#### REGISTRATION

The registration and information desks will be located in the lobby of the Princess Issena Hotel, with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests and ladies are required to register. Tickets for the dinner, Tuesday evening, May 2, may be obtained at the hotel desk. Cost of dinner included in hotel rates for those residing at Princess Issena Hotel.

#### HOTEL

PRINCESS ISSENA—*Convention Headquarters.*  
(American Plan)

Single - \$7.00      Double - \$6.00

*No extra charge to guests for Tuesday night Dinner tickets.*

#### TECHNICAL EXHIBITS

Technical exhibits will be located in the lobby of the Princess Issena Hotel.

The technical exhibits have a real scientific value and physicians who wish to keep abreast of the times and know the latest in drugs and medical appliances should spend some time with these exhibits. It will be surprising the amount of useful information that can be procured at these exhibits. Many have nothing for sale, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Daytona Beach meeting:

American Optical Company  
A. M. Bidwell, M.D.  
Bard-Parker Company, Inc.  
Everhart Surgical Supply Co.  
H. G. Fischer & Company  
C. B. Fleet Co.  
General Electric X-Ray Corp.  
Jones Metabolism Equipment Co.  
Keleket X-Ray Co. of Florida  
Lederle Laboratories, Inc.  
Eli Lilly & Co.  
J. B. Lippincott Company  
M & R Dietetic Laboratories  
Mead Johnson & Company, Inc.  
The Wm. S. Merrell Company  
Miami Surgical Co.  
Parke, Davis & Co.  
Pet Milk Company  
Petrolagar Laboratories, Inc.

Philip Morris & Co., Ltd., Inc.  
J. Sklar Mfg. Co.  
Southeastern Optical Company  
E. R. Squibb & Sons  
Surgical Supply Company  
Table Rock Laboratories  
Westinghouse X-Ray Company, Inc.  
White Belt Dairies

#### SCIENTIFIC EXHIBITS

The scientific exhibits will be located on ground floor of west wing of the Princess Issena Hotel.

We consider ourselves fortunate to be able to present for your approval the following exhibits:

1. Florida Society of Dermatology and Syphilology.
2. Florida Tuberculosis Sanatorium.
3. Florida Women's Field Army of the American Society for the Control of Cancer.

#### GOLF

The Annual Handicap Golf Tournament for members of the Florida Medical Association will be played at the beautiful seaside course, Seabreeze Golf Club, which is only a few blocks from the Princess Issena Hotel. Time: Sunday afternoon, April 30, Monday and Tuesday, May 1 and 2.

Rules: U. S. Golf Association. See card for local rules.

Handicaps: Three-fourths official handicap with a maximum of 27 strokes. The entrant must state his handicap to the starter before beginning the tournament round. In case the player does not possess a handicap, one will be given to him by the starter. Practice rounds are permitted.

Grounds fees for guests showing F. M. A. badges will be \$1.00.

Score card: Must be dated, signed, attested and turned in to the starter at the end of the tournament round.

Prizes awarded for 18 holes play as follows:

First Prize: Orlando Cup (low net score).

Other prizes to be announced later.

For additional information, communicate with Dr. J. R. Chandler, Chairman of Golf Committee, 110 S. Ridgewood Ave., Daytona Beach, Fla.

#### SKEET AND TRAP SHOOTING

Skeet and Trap Shooting events will take place at the Daytona Beach Gun Club on Sunday April 31 and Tuesday May 2 at 3 p.m. Refreshments will be served and trophies awarded to all classes. Charges will be made for shells and birds. Arrangements in advance should be made with Dr. Maximilian Stern, 223 Ocean Boulevard, Daytona Beach, Florida. Those not making arrangements in advance will be given an opportunity to register immediately upon their arrival in Daytona Beach.

## FISHING TRIPS

Half-day fishing trips for parties of four to six will be arranged for the convenience of those interested in this sport. Applications should be made to Dr. Harold Miller, Chairman Anglers' Committee, 201 Canal Street, New Smyrna Beach, Florida. Parties will be taken on half-day trips arranged for either mornings or afternoons from New Smyrna Beach which is 14 miles from Daytona Beach. It is arranged this way rather than to embark at Daytona Beach in order to save time to the fishing banks. Applicants for fishing trips will be consulted with regard to the time most convenient for them. Those not making previous application will also be given an opportunity to register for them soon after their arrival in Daytona Beach.

## OFFICERS OF VOLUSIA COUNTY MEDICAL SOCIETY

B. E. MILLER, *Honorary President*  
 MAXIMILIAN STERN, *President*  
 L. V. L. BROWN, *Vice President*  
 R. L. MILLER, *Secretary-Treasurer*

## LOCAL COMMITTEES

## Cabinet

J. Ralston Wells, *Chairman*

W. C. Chowning  
 R. L. Miller  
 Maximilian Stern  
 Ludo von Meysenbug

W. C. Chowning *Cabinet Member*

## Registration

## Greeters'

T. F. Hahn, *Chairman*  
 L. B. Bouchelle  
 J. E. Taylor, *Chairman*  
 J. E. Rawlings

## Ladies' Advisory

Harry Silsby  
 J. R. Vallotton

M. Josie Rogers, *Chairman*  
 H. L. Merryday  
 J. E. Taylor

R. L. Miller, *Cabinet Member*

## Finance

## Transportation

Hugh West, *Chairman*  
 George A. Davis  
 H. W. Henry  
 Roy Howe  
 H. L. Merryday, *Chairman*  
 A. E. Drexel  
 Carroll B. Jones

## News

## City Decoration

Evans B. Wood, *Chairman*  
 C. E. Tribble  
 C. O. Sayres  
 C. A. Clemmer, *Chairman*  
 T. H. Dillard  
 Raymond Howe

Maximilian Stern, *Cabinet Member*

## Golf

## Scientific Exhibits

J. R. Chandler, *Chairman*  
 A. E. Drexel  
 George M. Green  
 P. A. Drohommer, *Chairman*  
 B. E. Miller  
 Fred Puleston

## Anglers'

## Trapshooters'

Harold E. Miller, *Chairman*  
 Joseph B. Davis  
 Evans B. Wood  
 J. E. Rawlings, *Chairman*  
 M. J. Myres

Ludo von Meysenbug, *Cabinet Member*

## Association Dinner

## Lantern-Loud Speaker

George M. Green, *Chairman*  
 P. A. Drohommer  
 W. C. Pay  
 C. E. Tribble  
 Joseph B. Davis, *Chairman*  
 Raymond Howe  
 C. O. Sayres  
 J. R. Vallotton

## Jamboree

## Alumni and Fraternity

J. H. Rutter, *Chairman*  
 J. R. Chandler  
 C. W. Davis  
 M. B. Seltzer  
 Luncheons  
 M. J. Myres, *Chairman*  
 L. V. L. Brown  
 L. W. Glatzau  
 P. L. Moon, Jr.

## MONDAY

## FIRST MEETING OF HOUSE OF DELEGATES

Monday, May 1, 9 a. m.

Inn Dining Room

President Spiers in the Chair.

Roll Call and seating of delegates.

Adoption of minutes as published in June, 1938, Journal.

Recognition of Delegates to A. M. A.: Meredith Mallory and Herbert L. Bryans. (*Official report read at meeting of Executive Committee and published in October, 1938, Florida Medical Journal*).

Election of one delegate and one alternate to A. M. A. meeting for two-year terms.

(*A. M. A. By-Laws, Chapter 1, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve."*)

Reading of Resolutions.

Recommendations of Executive Committee.  
 Meeting Place, 1940.

Charter—County Medical Society.

Reports of Committees:

Council, Harrison A. Walker.  
 Scientific Work, Walter C. Jones, Jr.  
 Legislation and Public Policy, Horace A. Day.  
 Publication, Walter C. Jones, Jr.  
 Medical Education and Hospitals, John R. Chappell.  
 Public Relations, Roy J. Holmes.  
 Necrology, G. Walter Potter.  
 Medical Postgraduate Course, T. Z. Cason.  
 Cancer Control, James M. Hoffman.  
 Medical Economics, J. C. Vinson.  
 Inter-Relationship, William M. Rowlett.  
 Tuberculosis and Public Health, M. Jay Flipse.  
 State Controlled Medical Institutions,  
 H. D. Van Schaick  
 Maternal Welfare, Ferdinand Richards  
 Child Health, Luther W. Holloway.  
 Advisory to Woman's Auxiliary, Gordon H. Ira.  
 Representatives to Industrial Council, A. H. Weiland.  
 Venereal Disease Control, E. T. Sellers.  
 General Advisory Board of Past Presidents,  
 Henry E. Palmer.

New Business.

Announcements.

Adjournment.

## FIRST GENERAL SESSION

Monday, May 1, 1:30 p.m.

ASSEMBLY ROOM

Call to Order, President W. Henry Spiers.

Invocation, The Right Rev. Monsignor Wm. J. Mullally.

Address of Welcome, Hon F. V. B. Couch, Mayor,  
 Daytona Beach.

Address of Welcome, Maximilian Stern,  
 President Volusia County Medical Society.

Report of our Delegates to Georgia Medical Association  
 Convention:

Gerry R. Holden  
 Homer L. Pearson  
 Walter C. Page



Introduction, Delegates from other State Societies:

W. W. Anderson, Atlanta,  
Arthur G. Fort, Atlanta,  
T. C. Davison, Atlanta,  
Charles R. Andrews, Jr., Canton, Ga.

New Business.  
Announcements.

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Walter C. Jones, Miami; Roscoe H. Knowlton, St. Petersburg; John S. McEwan, Orlando; James H. Pound, Tallahassee; Harry F. Watt, Ocala; Herbert E. White, St. Augustine.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

PROJECTORS

The Committee on Projecting Lantern has arranged for a projecting lantern and daylight screen for use during the convention. An operator will be available at all times.

FIRST SCIENTIFIC ASSEMBLY

*Monday, May 1, 2:30-6 p. m.*

ASSEMBLY ROOM

1. "Puerperal Infections Versus the General Practitioner," William C. Roberts, Panama City.  
Prophylactic aspect of puerperal infections from a practical viewpoint. The more common of the many bacterial causes of infection are discussed, together with present-day methods of treatment.  
Discussion: J. M. Hoffman, Pensacola;  
D. Angus McKinnon, Marianna.
2. "Five Hundred Consecutive Operative Gynecological Cases," Ferdinand Richards, Jacksonville.  
This work represents unselected private and service cases treated in the hospitals of Jacksonville in the past five years. The report includes preoperative and postoperative treatment, pathological and final diagnosis, together with the operation, mortality rate and end results.  
Discussion: C. J. Collins, Orlando;  
Cayetano Panettiere, Miami Beach.
3. "Treatment of Automobile Accidents," E. B. Hardee, Vero Beach.  
Statistics on number of accidents, mortality and morbidity. Some recognizable features of injuries from automobile accidents. Importance of immediate treatment, ambulance transportation and careful handling. Report of cases involving fatal and minor injuries. Residual treatment.  
Discussion: J. Ralston Wells, Daytona Beach;  
Van William Burns, Stuart.
4. "Some Observations on the Treatment of Pellagra," J. Frank Wilson, Jacksonville.  
A brief review of some treatments used in the past. The beginning of modern treatment based on the work of Goldberger. More recent developments, with a comparison of results obtained by several methods.  
Discussion: Rothwell Lefholz, Miami;  
G. C. Bottari, Tampa.
5. "Eugenic Sterilization," A. T. Cobb, Gainesville.  
Principles involved. Summary of arguments pro and con, with personal thoughts and observations. Review of results in other states where sterilization laws exist, with advocacy of such a statute for Florida.  
Discussion: W. H. McCullagh, Jacksonville;  
J. C. Robertson, Chattahoochee.
6. "Public Health Yesterday, Today, and Tomorrow," W. A. McPhaul, Jacksonville.  
Early public health problems which led to the establishment of the Florida State Board of Health. Present day health program. Tomorrow's needs; proposed legislation toward more adequate medical and hospital care; the place of public health in this legislation.  
Discussion: Geo. N. MacDonell, Miami;  
J. R. McEachern, Tampa.

LADIES' AND GENTLEMEN'S JAMBOREE

*Monday, May 1, 8:00 p. m.*

Pier Casino  
(Informal)

Our Master of Ceremonies Says  
Come Prepared to  
Eat — Drink — Dance — and Be Merry

TUESDAY

SECOND SCIENTIFIC ASSEMBLY

*Tuesday, May 2, 9-11 a. m.*

ASSEMBLY ROOM

7. "The Thyroid and Adrenal Glands as Factors in the Control of Fever, Heat Regulation, and Climate," N. L. Spengler, Tampa.  
Development of adrenal gland; its function in early infancy. Heat control and regulation in hot and cold climates. Man's adaptability to different climates. Case reports of thyroid and adrenal deficiency, and one case of diabetes insipidus in a child born of a myo-edematous mother which developed during pregnancy.  
Discussion: J. R. Boulware, Jr., Lakeland;  
Frank S. Adamo, Tampa.
8. "Hyperthyroidism — Medical Phases." (Lantern Slides), Webster Merritt, Jacksonville.  
Diagnosis of hyperthyroidism and observations on the value of the heart disturbance as an indication; the similarity to severe heart disease from other causes; the preparation of the patient for thyroid surgery.
9. "Hyperthyroidism — Surgical Aspects," (Lantern Slides), W. Duncan Owens, Miami Beach.  
Embryology and anatomy of the thyroid gland. Incidence of hyperthyroidism, especially in southern Florida. Pathology of the types of hyperthyroidism. Diagnosis. Treatment. X-ray therapy vs. surgery. Choice of anesthetic. Staged operations. Surgical technique and amount of gland to be removed. Prognosis. Recurrences.  
Discussion: Frank G. Slaughter, Jacksonville;  
Fred Mathers, Orlando;  
Edward Jelks, Jacksonville.

SECOND GENERAL SESSION

*Tuesday, May 2, 11 a. m.*

ASSEMBLY ROOM

Call to Order, W. Henry Spiers, President.

Reports of Officers and Committees:

Secretary-Treasurer-Editor, Shaler Richardson, and  
Managing Director, Stewart Thompson. (Lantern Slides).

Executive Committee, Gilbert S. Osincup.  
President's Address, W. Henry Spiers, Orlando.

THIRD SCIENTIFIC ASSEMBLY

*Tuesday, May 2, 2-5 p. m.*

ASSEMBLY ROOM

10. "Atrophic Rhinitis and Otosclerosis," (Lantern Slides), S. B. Forbes, Tampa.  
Cases which definitely belong to the dyspituitary group. Reaction on nasal mucosa of female sex hormone. Case histories: estrogenic treatment combined with ivory implant into nose; estrogenic treatment alone. Otosclerosis with estrogenic treatment and thyroxine intratympanic injections. Audiograms of cases shown.  
Discussion: H. Marshall Taylor, Jacksonville;  
Gail E. Chandler, Miami.
11. "The Importance of Case Records Relative to the Cancer Problem," (Lantern Slides), R. L. Ellison, Ft. Lauderdale.  
Theory of genetic origin of tumors supported by their simultaneous and symmetrical occurrence in homologous twins and high incidence of cancer in certain families. Maude Slye's work on the heredity of cancer in mice. Bittner's feeding experiments. Research work on proliferation promoting substances. Plea for adoption of uniform forms for recording cancer records.  
Discussion: E. M. Hendricks, Ft. Lauderdale;  
F. K. Herpel, West Palm Beach.

12. "Pediatrics Fifty Years Ago and Today," William W. McKibben, Miami.  
Highlights of the diagnostic and therapeutic advances in pediatrics in the last half century. The pitifully dark empirical days of the horse and buggy doctor, followed by two schools of thought: that of pathology by Virchow; and the new school of bacteriology, exemplified by Pasteur. Rapid strides since made by pediatrics. Examples.  
Discussion: Douglas D. Martin, Tampa;  
Luther W. Holloway, Jacksonville.
13. "Management of Injuries to the Ureter," (Lantern Slides and Motion Pictures), Robert B. McIver, Jacksonville.  
Cause: Direct Trauma, (a) gunshot and stab wounds, (b) operations, accidental and intentional; Indirect Trauma, (a) calculi either in passage or impacted, (b) disease processes, in ureter itself, and extension from other organs. Treatment: depends on stage in which condition is recognized, (a) immediate repair by suture or anastomosis, (b) indwelling catheter, (c) plastic operations—on ureter, anastomosis to skin, anastomosis to intestine; nephrectomy. Case reports.  
Discussion: Louis M. Orr, II, Orlando;  
E. Clay Shaw, Miami Beach.
14. "Treatment of Hip Fractures by Internal Fixation," (Motion Pictures), Arthur H. Weiland and Charles R. Burbacher, Coral Gables.  
History of the development of present care in hip fractures. Statistics of end results of fractures of the hip with conservative treatment as compared with internal fixation. Colored motion picture film showing technique employed by authors.  
Discussion: Prescott LeBreton, St. Petersburg;  
Frank L. Fort, Jacksonville.
16. "Acute Appendicitis," Lloyd J. Netto, West Palm Beach.  
Review of mortality statistics for past 10 years. Present status of treatment of all forms, with comments. Appendicitis at Good Samaritan Hospital for past 5 years; types of operations; mortality. Summary.  
Discussion: George D. Lilly, Miami;  
Don C. Robertson, Orlando.
17. "Gastric and Duodenal Surgery," (Lantern Slides), Ralph A. Gowdy, Miami Beach.  
Thousands die from gastric carcinoma who could be cured by surgery. Different types of gastric resection. Sequelae of various operative procedures and their management. Duodenal ulcers considered medical unless complications occur. Most gastric lesions are surgical. Preoperative and postoperative lantern slides of various duodenal and gastric lesions.  
Discussion: Frederick J. Waas, Jacksonville;  
Walter C. Jones, Miami.

### THIRD GENERAL SESSION

Wednesday, May 3, 11 a.m.

#### ASSEMBLY ROOM

President Spiers in the Chair.

Address (by invitation) "Brain Abscess," Joseph E. J. King, Director of Neurosurgery at Bellevue Hospital, Lenox Hill Hospital, New York Polyclinic Hospital and the Hospital for the Ruptured and Crippled, New York City.

Unfinished Business.

New Business.

Election of President-elect.

Election of First Vice-President.

Election of Second Vice-President.

Election of Third Vice-President.

Election of Secretary-Treasurer and Editor of Journal.

Dr. Leigh F. Robinson escorted to the Chair as new President.

Presentation of Past-President's Button to Dr. W. Henry Spiers by Dr. Henry E. Palmer.

Adjournment.

### SECOND MEETING OF HOUSE OF DELEGATES

Tuesday, May 2, 5 p.m.

#### INN DINING ROOM

Roll Call.

Unfinished Business.

*Two members of Advisory Board of Past Presidents granted privileges of floor, one to present recommendations of majority and one to represent the minority.*

### ASSOCIATION DINNER

Tuesday, May 2

#### PRINCESS ISSENA HOTEL

- 7:30 p. m. Dinner. Judge Herbert B. Frederick, toastmaster, introduced by J. Ralston Wells. Short talks by W. Henry Spiers, president; Leigh F. Robinson, president-elect; and Maximilian Stern, president, Volusia County Medical Society.

Entertainment. *Dinner Tickets (\$2.00) may be obtained at hotel desk by persons not residing at headquarters hotel. Cost of dinner is included in hotel rate for those registered at Princess Issena Hotel.*

- 9:30 p. m. Motion Pictures—Assembly Room.

### WEDNESDAY

#### FOURTH SCIENTIFIC ASSEMBLY

Wednesday, May 3, 9-11 a. m.

#### ASSEMBLY ROOM

15. "Acute Intestinal Obstruction: Diagnosis and Physiologic Treatment," (Lantern Slides), Hugh West, DeLand.  
Changes in blood chemistry: concentration of blood, change in amount of chlorides, carbon dioxide, and proteins. Explanation of physical signs: gurgling sounds, tinkling sounds, and increased sounds of the abdominal aorta. Explanation of the pain. Treatment: restoration of blood chemistry to normal, decompression of distended gut before operation, localization of obstruction by means of Miller Abbott tube and x-rays.  
Discussion: Jos. S. Stewart, Miami;  
Frank D. Gray, Orlando.

### SPECIAL GROUP MEETINGS

#### EIGHTH ANNUAL SPRING MEETING OF THE FLORIDA RADIOLOGICAL SOCIETY

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H. B. McEuen, Vice-President.....Jacksonville  
Jos. H. Lucinian, Secretary.....Miami

Sunday, April 30

#### RECREATION ROOM

2:00 p.m. Round table discussion and exhibit of films.

7:00 p.m. Round table discussion and exhibit of films.

Monday, May 1

#### RECREATION ROOM

9:00 a.m. Therapy discussion.

11:30 a.m. Election of Officers.

FOURTH ANNUAL MEETING OF THE  
FLORIDA PEDIATRIC SOCIETY

OFFICERS

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Ludo von Meysenbug, Vice-President..Daytona Beach  
Warren W. Quillian, Secretary.....Coral Gables

*Sunday, April 30*

PRINCESS ISSENA HOTEL

4:00 p.m. Guest Speaker, Robert A. Strong, Professor  
of Pediatrics, Tulane University, New  
Orleans.

8:00 p.m. Dinner Meeting. Guest Speaker, Robert A.  
Strong, New Orleans.

Round Table Discussion.

Business Meeting.

Election of Officers.

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ROUND TABLE DISCUSSION

*Sunday, April 30, 1939*  
ASSEMBLY ROOM

8:00 p.m. President Herman Watson, presiding.

GENERAL SESSION

*Monday, May 1, 9:00 a.m.*  
ASSEMBLY ROOM

Call to Order, Herman Watson, President.  
Invocation.  
Address of Welcome.  
Minutes.  
Reports of Committees.  
President's Address.

SCIENTIFIC PROGRAM

*Papers limited to fifteen minutes each. Discussion in  
total limited to fifteen minutes.*

1. Guest Speaker, Joseph D. Collins, Chief Surgeon,  
Seaboard Air Line Railway, Norfolk, Virginia.
2. "Infection of Hand," C. C. Webb, Pensacola.
3. "The Necessity of the Adequate X-Ray Examina-  
tion in Trauma," H. B. McEuen, Jacksonville.
4. "Treatment of Minor Injuries," T. H. Bates, Lake  
City.
5. "Treatment of Major Injuries," Frank D. Gray,  
Orlando.

BUSINESS MEETING

Election of Officers and Induction into Office.  
Announcements.  
Adjournment.

FLORIDA INTERNISTS' SOCIETY

OFFICERS

Norval M. Marr, Chairman.....St. Petersburg  
Kenneth Phillips, Secretary.....Miami

*Monday, May 1*

SEMINOLE COTTAGE LOWER LIVING ROOM

11:00 a.m. Scientific Session.  
12:00 noon Luncheon—Dining Room.

REGULAR QUARTERLY MEETING OF THE  
FLORIDA SOCIETY OF DERMATOLOGY  
AND SYPHILOLOGY

OFFICERS

Elmo D. French, President.....Miami  
Lauren M. Sompayrac, Secretary.....Jacksonville

*Monday, May 1, 12 noon*

PRINCESS ISSENA HOTEL DINING ROOM, ANNEX N. E.  
Business Meeting.

Election of Delegates to the Tenth International  
Congress of Dermatology.

Luncheon for Visiting Dermatologists.

FLORIDA SECTION  
SOUTHEASTERN SURGICAL CONGRESS

*Monday, May 1, 11 a.m.*

HIAWATHA COTTAGE LIVING ROOM

Business Meeting.

WOMAN'S AUXILIARY

*Local Committee on Arrangements*

Mrs. Harry L. Merryday, General Chairman.  
Mrs. J. Ralston Wells, Publicity.  
Mrs. Maximilian Stern, Tea.  
Mrs. J. B. Davis, Transportation.  
Mrs. L. W. Glatzau, Registration.  
Mrs. Evans B. Wood, Auxiliary Meeting.  
Mrs. R. L. Miller, Information.  
Mrs. C. A. Clemmer, Luncheon.  
Mrs. Ludo von Meysenbug, Hospitality.

PROGRAM

*Monday, May 1*

- 1:30 p.m. Cars leave Princess Issena Hotel for drive  
on world famous beach.
- 3:30 p.m. Tea at Sun and Surf Club  
(Hostesses: ladies from New Smyrna).
- 8:00 p.m. Ladies' and Gentlemen's Jamboree, Pier  
Casino.

*Tuesday, May 2*

- 9:30 a.m. General Auxiliary Session, Princess Issena  
Hotel, Inn Dining Room, followed imme-  
diately by a post-convention Board meeting.
- 1:00 p.m. Luncheon, Princess Issena Hotel Dining  
Room.  
(Hostesses: ladies from DeLand).
- 7:30 p.m. Association Dinner, Princess Issena Hotel  
Dining Room.



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(Address all communications to Box 1018, Jacksonville)

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## NOTICE TO DELEGATES AND COMMITTEE CHAIRMEN

The first meeting of the House of Delegates will be held Monday morning, at 9 o'clock on May 1 in the Inn dining room of the Princess Issena Hotel, Daytona Beach. The entire forenoon Monday, if necessary, will be devoted to important matters for action of the House of Delegates. Reports of standing committees will be read at this first meeting.

Chairmen of standing committees are urged to be present on time, in order that their reports may follow the published schedule as shown in the program in this issue of the *Journal*.

Delegates and committee chairmen, please note the time and date of this first meeting of the House of Delegates—9 a. m., Monday, May 1.

Refer to page 509 for complete program of the Annual Meeting at Daytona Beach. Elaborate preparations have been made for entertainment and all members of the Association are urged to be present.

## WHERE ARE WE GOING?

The thought foremost in the minds of the medical profession today is relative to Socialized Medicine. What is in store for us? What form will the National Health Program take? What salary will I be expected to work for? How will all this effect me personally, my income, my hours and my standard of living? These are all questions we would like very much to have answered, for if we knew these answers, we could much more sensibly discuss the problems before us.

Although it is impossible to know just what the future holds for us, would it not be wise for us, as a profession, to take stock of ourselves and our work personally, and see wherein we could improve ourselves and our work? We like so much to talk about cleaning house, yet we all know the only way to do such a thing is to begin and probably end in our own hearts and minds and lives.

Let us ask first why we continue to cling so tenaciously to that Lowly One who trod the Gallilean hills and healed the sick? Is it because that One has ever been the Example and Guide for those of us who strive to practice the healing arts? Or is it because we, as a profession, have been put upon a pedestal, and have so many times been likened to the Great Physician? Have we been held up and praised so much that we are beginning to believe we are the "King" and "The King can do no wrong?"

Am I becoming such a "money grabber" that I hate to see an unfortunate one come in who I am afraid is unable to hand out a few dollars for the measly help I am able to give? Am I becoming so low that I like to see the charity work that I do paraded before the public so they might see how great I am? Have I become so high and mighty that I cannot sit humbly at the bedside of the lowly and with charity in my heart dispense loving kindness as well as a few horrible pills I might have?

Heaven help us to take stock and to read-just ourselves, that we might be living examples of the "charity" that this old world is crying out for. It will then no longer be necessary to wonder where we are going; we will have arrived.



## BRINKLEY LOSES SUIT AGAINST EDITOR OF HYGEIA, THE HEALTH MAGAZINE

"The suit for libel and damages filed by John R. Brinkley against the Editor of *Hygeia* was called in the federal court at Del Rio, Texas, on Wednesday, March 22," *The Journal of the American Medical Association* for April 8 says. "A jury consisting largely of residents of the vicinity of Del Rio was impaneled and evidence began to be offered by the plaintiff on the afternoon of the same day. In the course of the trial the plaintiff, Dr. John R. Brinkley, offered in evidence not only his own testimony but that of his associates; also a number of character witnesses. It was the decision of the court that patients would not be allowed to testify as to the results of any procedures performed on them. For the defendant there appeared three experts: Drs. Alfred I. Folsom, Dallas; Benjamin Weems Turner, Houston, and Charles S. Venable, San Antonio; also a chemist of the American Medical Association, Dr. E. W. Schoeffel, Chicago. Furthermore, there were read into the record several depositions containing evidence prepared for a previous suit of a similar character which was dismissed. Among the exhibits offered were most of the pamphlets circulated by the plaintiff and a book concerned with his biography written by Clement Wood and entitled 'The Story of a Man.' Following the completion of the evidence, which required four full days, attorneys for both sides presented the case to the jury and the instructions were given to the jury by Judge R. J. McMillan. After a consideration of several hours, the jury returned its verdict for the defendant. In a future issue of *The Journal* (probably the issue of April 22) and also in *Hygeia* it is proposed to present a complete abstract of the evidence and the instructions of Judge McMillan to the jury."

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*Editor's Note—A number of favorable comments have been received on the following editorial, published in the April, 1939 Bulletin of the Dade County Medical Association, and it has been suggested that a reproduction be published here for the benefit of our readers.*

### PERFIDIOUS DISCUSSORS

Last year I listened with interest to the reading of a paper entitled, "Pitfalls in the Diagnosis of ———." The man chosen to lead the discussion then remarked: "I was surprised that the essayist did not take up the new treatment of this condition so I will discuss the paper from the treatment angle." This statement hit me like a blow from a well-developed fist. The essayist had worked hard and presented well, the diagnostic points and I know he wanted to hear the opinions of the discussors on his ideas about diagnosis. Imagine his chagrin or even humiliation to see his subject thrown away and a new one substituted.

I have thought much and listened well since then and have heard a few good discussions and many that were bad. I have asked some of my friends what they thought of the average discussion locally and they were unanimous in the opinion that there is much room for improvement.

Within the past several months we have heard a discussor, supposedly limited to five minutes, read a paper lasting thirteen minutes, going over in detail the exact points covered by the essayist. And we have heard another discussor omit mention of the pertinent points in the paper to branch off into byways not even suggested by the essayist.

I suggest this question: "Why do we have a formal leader of the discussion?" Is it not that the audience and the essayist may have the benefit of the opinion of another man on the subject matter of the paper, based on his own experience? Surely the audience does not care to hear another paper. Surely the essayist does not care to be humiliated by having his paper ignored,

apparently as worthless, by his discussor taking up a phase of the subject entirely foreign to the point of the paper!

It is manifestly impossible for any man to cover all parts of any one subject in the twenty minutes allotted. Those who must listen are happy, extremely happy, that this is so. Now, does the audience, the long suffering listeneres, care to hear the discussor go into detailed description of parts of the subject not covered by the essayist? Vehemently, I say "NO!" Those with whom I have conferred are unanimous in condemnation of such tactics.

Perhaps there is another side to the question. Perhaps you disagree with the ideas expressed here as strongly as I deplore and condemn the type of discussions mentioned above. I would like to know just how you feel. A discussion of this matter must result in improvement in our programs.

Many of us believe the discussor should:

1—Confine his remarks to the subject matter covered by the paper and never wander off into the myriad possibilities of points not covered by the essayist, nor into the byways of irritating repetition.

2—Emphasize points with which he is in agreement.

3—Feel free to disagree with any or all parts.

4—Give his own experience and statistics with similar cases.

5—Never run over his allotted time.

6—Be ever courteous to the essayist.

7—Above all, remember, that he is discussing a paper, not reading one.

JOS. S. STEWART, M. D.

### CONVENTION NOTES

*To the Editor:*

As we advance in years and experience we should grow "every day in every way better and better." This is undoubtedly true of our Florida State Conventions. Each succeeding year we think is the best so when Daytona Beach was chosen for the 1939 Convention one naturally knows we will be expected to continue the improvement. To come up to last year's meeting in Miami, let alone improve upon it, is almost too much to expect, or so we thought, but Volusia will be proud to be hosts to the Convention and if our humble efforts give you all a good time we will be happy.

No efforts will be spared to make this a meeting to remember. Of course, we have the Beach to help our efforts and one of the best County Societies in the State. We hope you will be so pleased that you may be tempted to stay over a few days after the official closing.

Our boys will all be labeled as "Hosts," and our girls as "Hostesses." We mean just that, walking information Bureaus and Chesterfieldian hospitality. Just ask us—anything—and if we don't know, we'll tell you something anyhow.

Our hospital, Halifax District Hospital, which is as good as the best, will be open for inspection and all guests are cordially invited by the Board to visit it. There are no clinics arranged because Monday morning will be amply filled by the House of Delegates Meeting and Special Societies.

Monday Night—now here is a real time. The ladies added so much to last year's "Smoker," that we are following suit. We have a Master of Ceremonies, Charles Herring, "Charlie" to you, to conduct and how he can do it. We know and you will find out. Forget all worry and care as you enter the Pier stretching far out over the ocean. It is all yours. There will be





plenty of beer, food and entertainment, and even the most decrepit and aged will forget their age and infirmity. And the dance-orchestra—such syncopation and rhythm will be beyond description.

As for fishing, shooting and golf—fishing, both river and ocean as you desire; a gun club that has everything and expects you to try your skill; as to golf, we have grown some special greens for your benefit! The annual tournament, prizes and even a “nineteenth hole.”

The Dinner, Tuesday night. You'd better go light on lunch at noon so you will have enough capacity. Our genial Host, Mr. Henry Haynes, “knows how.” Fact, he promises a dinner that will make you remember the Princess Issena Hotel for many years to come. After the Dinner we are indulging in a new idea—real movies—some serious—some ridiculous, all darned good. Don't be alarmed, you will all be let out early enough to go on your own “Night Clubbing,” and Charlie's Hi Hat Club across the street will finish you off properly.

The ladies have ordered a special low tide in the ocean, so you can enjoy the beach and they have planned rides, bathing and entertainment at the beach clubs. These girls of ours have planned such a series of good times that it is hard for us to keep up to them, so you ladies who haven't “quite made up your minds,” just decide right now to come and chaperon friend husband. He'll need it.

We are warning you, just don't miss this visit to Daytona Beach.

From all reports, this will be numerically the largest Convention ever held by the Florida Medical Association and we hope, the best. Nothing too small for us to do, nothing so large that we can't handle it. We want each one, individually, and we want you all.

*Cabinet Committee of the  
Volusia County Medical Society.*

P. S. Don't forget if you like Daytona Beach that the Postgraduate School is being held here in July.

We are proud to have this meeting which each year seems to be better than the last. If you know all there

is to learn about medicine, don't come. But if there is one little point you don't know, join the school boys and you surely will learn all about it.

*J. Ralston Wells, M. D., General Chairman.*

*To the Editor:*

#### THE SPORTS PROGRAM

##### GOLF

Golf has been arranged for by Doctors J. R. Chandler, George Green and A. E. Drexel at the Seabreeze Golf Club. For members desiring to get their golf in before the business of the Convention begins, the Committee has arranged play for Sunday afternoon, but for those finding time the course will be open for them all day Monday and Tuesday. Again, the Orlando cup will be awarded to the low net score, and many other prizes will be awarded those in the lower brackets. The Seabreeze course is in fine condition and beautifully situated near the ocean shore.

##### SKEET AND TRAP SHOOTING

Skeet and Trap Shooting will be available at the Daytona Beach Gun Club Sunday afternoon for the early comers, and also on Tuesday and Wednesday afternoons. The Daytona Beach Gun Club is well equipped for the entertainment of visitors, and refreshments will be available at all times. The Committee on Skeet and Trap Shooting is presided over by Doctors Maximilian Stern, J. E. Rawlings and M. J. Myres. Those desiring to engage in this sport should communicate with Doctor Stern either in advance or immediately upon their arrival in order that they may be escorted to the Gun Club, and suitable squads arranged.

##### FISHING

Half-day fishing trips for parties of four to six will be arranged for the convenience of those interested in this sport. Applications should be made to Doctor Harold Miller, Chairman Anglers' Committee, 201 Canal Street, New Smyrna Beach, Florida. Parties will be taken on half-day trips arranged for either mornings or afternoons from New Smyrna Beach, which is 14 miles from Daytona Beach. It is arranged this way—

rather than to embark at Daytona Beach in order to save time to the fishing banks. Applicants for fishing trips will be consulted with regard to the time most convenient for them. Those not making previous application will also be given an opportunity to register for them soon after their arrival in Daytona Beach.

The Sports Committee is anxious to impress upon all members that they are in a position to amply repay those who take the trouble to come equipped with their golf sticks, guns and fishing tackle. To facilitate matters—a word in advance would be much appreciated.

*Sports Committee,  
Maximilian Stern, M. D.  
Cabinet Member.*

*To the Editor:*

#### ALUMNI AND FRATERNITY LUNCHEONS

These functions are becoming more and more important in the mosaic of the annual state convention. Our county membership has constituted itself a committee of the whole, so that almost every Medical College has an Alumnus ready to head a congenial group of old grads. Please register your college and fraternity on your arrival and sign up for these luncheons. As soon as our committee knows how many and whatever, it will get busy and arrange for the time and place and notify you in turn.

A list of Colleges and Fraternities represented in our county, and the doctor representative is:

*Emory:* Calvin W. Davis, Daytona Beach, '14; George A. Davis, DeLand, '90; Joseph B. Davis, Daytona Beach, '15; Thos. H. Dillard, DeLand, '23; P. L. Moon, Jr., Pierson, '31; Hugh West, DeLand, '23.

*U. of Georgia:* Louis Bouchelle, New Smyrna, '91; A. E. Drexel, Daytona Beach, '29; H. E. Miller, New Smyrna, '29; Joseph E. Taylor, DeLand, '13; Ralph Vallotton, Daytona Beach, '34.

*Columbia:* M. J. Myres, Daytona Beach, '04; Maximilian Stern, Daytona Beach, '00. *U. of Iowa:* Fred Puleston, Daytona Beach, '01. *Jefferson:* R. L. Miller, Daytona Beach '17. *Johns Hopkins:* Evans B. Wood, Daytona Beach, '14. *U. of Louisville:* Harry L. Merryday, Daytona Beach, '14; W. C. Pay, New Smyrna, '94.

*U. of Maryland:* W. C. Chowning, New Smyrna, '04; L. W. Glatzau, Daytona Beach, '16; H. W. Henry, New Smyrna, '91; J. E. Rawlings, Daytona Beach, '04; J. H. Rutter, Daytona Beach, '28. *U. of Michigan:* Raymond Howe, Daytona Beach, '12; Roy Howe, Daytona Beach, '05.

*Vanderbilt:* Carroll B. Jones, New Smyrna, '28. *U. of Virginia:* Chas. A. Clemmer, Daytona Beach, '07. *Yale:* T. F. Hahn, DeLand, '33; C. E. Tribble, DeLand, '34. *U. of Pennsylvania:* L. V. L. Brown, DeLand, '02; J. Ralston Wells, Daytona Beach, '12. *Harvard:* Ludo von Meysenbug, Daytona Beach, '17. *Med. Col. So. Carolina:* J. R. Chandler, Daytona Beach, '24; George M. Green, Daytona Beach, '29.

*Hahnemann:* M. Josie Rogers, Daytona Beach, '07. *Keokuk:* W. G. Doern, Daytona Beach, '02. *U. of Toronto:* Morris B. Seltzer, Daytona Beach, '37. *College P. & S. Baltimore:* B. E. Miller, New Smyrna, '92.

A list of the most popular fraternities is: Alpha Kappa Kappa, Alpha Omega Alpha, Nu Sigma Nu, Phi Beta Pi, Phi Chi, Phi Delta Epsilon, Phi Rho Sigma, Theta Kappa Psi.

All other collegiate clubs are urged to renew allegiance to their old affiliations. No member of our County Society can qualify to lead some of these. Volunteer captains who started things for a group in Miami in 1938 please mail in names. We shall try to please you with all arrangements and details, and relieve you of those responsibilities so that all you will have to do will be to gather your group and let us do the rest.

Please send in your name, desires, and requirements to

*M. J. Myres, M. D., Chairman,  
Committee on Alumni and  
Fraternity Luncheons,  
258½ So. Beach Street  
Daytona Beach, Florida*

#### THE TECHNICAL EXHIBIT

The firms listed below will contribute materially to the success of the convention—also Table Rock Laboratories and White Belt Dairies, who purchased space just as this Journal was going to press. They all merit your support.

#### AMERICAN OPTICAL COMPANY

American Optical Company, Southbridge, Mass., manufacturer and distributor of ophthalmic products for more than a century, will exhibit its latest developments such as its recently developed Adaptometer for the detection of night blindness, etc., all of which are completely described in the recently released instrument catalogue which contains a hundred pages of new and improved instrumentation.

#### BARD-PARKER COMPANY, INC.

Among the Bard-Parker products exhibited at Booth No. 20 are Rib-Back Blades, Renewable Edge Stainless Steel Scissors, Lahey Lock Forceps, Formaldehyde Germicide and Containers for rust-proof sterilization of surgical instruments, and Hematological Case for obtaining blood samples at the bedside.

#### A. M. BIDWELL, M.D.

Dr. A. M. Bidwell of Tampa will exhibit the Bidwell T-Frame Leg Setting Apparatus. The T-Frame eliminates the need for various recent types of metal traction apparatus using wire rods passed through bones, which require the patient to remain in bed. The difficulty is not so much in reducing the fracture as holding it in place until plaster cast is applied. With Bidwell T-Frame this is accomplished in the vast majority of cases, allowing the patient to be ambulatory with crutches.

Its further advantages are that it eliminates extra assistants; made of wood, it does not throw x-ray shadow; is easily portable, easily assembled and knocked down.

#### EVERHART SURGICAL SUPPLY CO.

The Everhart Surgical Supply Company of Atlanta will have its exhibit in Space 27 at the Daytona Beach meeting. This firm has been serving doctors in Florida for the past twenty-three years, representing Hamilton Furniture, DeForest Diathermy equipment, and other leading well known surgical items. Mr. G. I. Butzer of Orlando is the Florida representative.

#### H. G. FISCHER & COMPANY

The latest Fischer Model of Short Wave, X-ray and other apparatus to be exhibited and demonstrated by H. G. Fischer & Co. will interest physicians because of their many unique features of design and performance. The complete Fischer line includes Shockproof X-ray apparatus, short wave units, combination cabinets, galvanic generators, ultraviolet and infra-red lamps, many other units, accessories and supplies. Physicians attending the convention are invited to ask for demonstrations of models in which they are interested or to consult with Fischer representative regarding technics made available by Fischer apparatus.

#### C. B. FLEET CO., INC.

Phospho-Soda (Fleet) is a highly concentrated and purified, aqueous solution of sodium phosphates. It is non-toxic, rapid but mild in action without irritation of the gastric or intestinal mu-



cosa. Indicated for hepatic dysfunction, and for its thorough eliminating and cleansing action on the upper and lower gut. C. B. Fleet Co., Inc., Lynchburg, Va.

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GENERAL ELECTRIC X-RAY CORP.

The General Electric X-ray Corp. will display an interesting group of X-ray and Physical Therapy apparatus. The exhibit will be in charge of their three full time Florida representatives, Messrs. Horton, Jongedyk and Mackel who will be pleased to demonstrate the equipment on display.

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JONES METABOLISM EQUIPMENT COMPANY

The Jones Metabolism Equipment Company in Booth 26 will feature as their display the Jones Motor Basal metabolism apparatus. A special feature of this unit is that it contains no water and requires no calculation in the determination of the basal metabolic rate.

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KELEKET X-RAY CO. OF FLORIDA

The Keleket X-Ray Co. of Florida invites you to visit its booth. Its representatives will be pleased to see you and give you information about the latest developments in X-ray, Physiotherapy, Electrosurgery and Electrocardiographs without obligation.

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LEDERLE LABORATORIES, INC.

Lederle Laboratories, Inc., who will exhibit in Booth 21, are pioneers in the development of Pneumonia Sera (now thirty types for treatment); Liver Extract Parenteral (15 U. S. P. units per cc.); Modified Globulin Antitoxins (fewer reactions); Immune Globulin (for modification of measles); Glycerolated Pollen Extracts (diagnosis and treatment); Allergenic Protein Extracts; Vitamin B Complex (biologically assayed); Vi-Delta Emulsion (high potency vitamins A and D).

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ELI LILLY AND COMPANY

Eli Lilly and Company of Indianapolis, will feature an eight-foot exhibit stressing the importance of liver extract in the treatment of pernicious anemia, Merthiolate (Sodium Ethyl Mercuri Thiosalicylate, Lilly), in the surgical and germicidal fields, Sodium Amytal (Sodium Isoamyl Ethyl Barbiturate, Lilly) in the field of hypnotics, and Iletin (Insulin, Lilly) in the management of diabetes mellitus. This is the first appearance of the Lilly Research Laboratories at the meeting of the Florida Medical Association and the exhibit unit has been specially designed for state medical meetings.

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J. B. LIPPINCOTT COMPANY

J. B. Lippincott Company will exhibit Thorek: *Modern Surgical Technic*; Rigler: *Outline of Roentgen Diagnosis*; Bacon: *Anus, Rectum, Sigmoid Colon*; Wilson: *Management of Fractures and Dislocations*; Maxson: *Spinal Anesthesia*; Spicer: *Trauma and Internal Disease*, and their full line of medical and surgical publications.

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M & R DIETETIC LABORATORIES

M & R Dietetic Laboratories, Inc., Columbus, Ohio, Booth 4, will display Similac and powdered SofKurd. Representatives will be glad to discuss the merit and suggested application of these products.

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MEAD JOHNSON & COMPANY

Three new Mead products will be on display at Mead Johnson & Company's Booth No. 7: Mead's Nicotinic Acid Tablets, Mead's Thiamin Chloride Tablets, Mead's Cevitamic Acid Tablets. Olac for feeding prematures will also be shown, as well as the complete line of Mead's Infant Diet Materials.

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WM. S. MERRELL COMPANY

The Wm. S. Merrell Company, Booth No. 5, will exhibit and explain to interested physicians the unique detoxicating properties of Soricin-Merrell, used in corrective treatment of the hypertoxic bowel. In addition to Soricin, other interesting Merrell specialties will be shown.

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THE MIAMI SURGICAL COMPANY

The Miami Surgical Company was established in 1926, taken over by B. Marian Beals in 1928, and incorporated in 1937, with Miss Beals as President-Treasurer.

The Miami Surgical Company is a thoroughly ethical firm and distributes all kinds of hospital and physicians' supplies, as well as laboratory equipment.

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PARKE, DAVIS & COMPANY

Members of the staff of Parke, Davis & Company will be at your service to tell you about some of their Research Staff's numerous scientific accomplishments. Mapharsen, Adrenalin, Pitocin, Pitressin, Theelin, Theelol, and biological products will be a part of this attractive exhibit.

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PET MILK COMPANY

An actual working model of a milk condensing plant in miniature will be exhibited by the Pet Milk Company in Booths 10, 11 and 12. This exhibit offers an opportunity to obtain information about the production of Irradiated Pet Milk and its uses in infant feeding and general dietary practice. Miniature Pet Milk cans will be given to each physician who visits the Pet Milk Booth.

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PETROLAGAR LABORATORIES

Physicians are cordially invited to visit booth No. 9 where Petrolagar Laboratories, Inc., will be represented by Mr. J. M. Carter. Petrolagar is liquid petrolatum 65 cc. emulsified with 0.4 Gm. agar in a menstruum to make 100 cc., accepted by the Council on Pharmacy and Chemistry of the American Medical Association for the specialized treatment of constipation. Scientific drawings and literature will be available in addition to samples of the five types of Petrolagar.

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PHILIP MORRIS & CO.

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

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J. SKLAR MFG. CO., BROOKLYN, N. Y.

The Sklar Manufacturing Company exhibit will feature new suction and pressure apparatus including the Improved Tompkins Portable Rotary Compressor, The De Luxe Tompkins, the new Imperatori apparatus for ear, nose and throat work.



Ralks' Ideal Unit and Moorhead Unit for office and clinic, and the new, improved heavy duty hospital model of the Bellevue Suction and Pressure Unit. The Sklar Company will also exhibit their extensive line of American made Stainless Steel Surgical Instruments, as well as special apparatus such as Davidson's Pneumothorax Apparatus, Soresi Blood Transfuser, etc. Booth No. 14.

#### SOUTHEASTERN OPTICAL CO.

The Southeastern Optical Co., Inc., distributes Ophthalmic Instruments and products of the Bausch and Lomb Optical Co. of Rochester and specializes in Quality Rx work. With offices in Jacksonville, Miami, St. Petersburg, and Tampa, they are prepared to render twenty-four hour service to any section of Florida.

#### E. R. SQUIBB & SONS

Physicians attending the Florida Medical Association meeting are cordially invited to visit the Squibb Exhibit in Booth No. 3. The complete line of Squibb Vitamin, Glandular, Arsenical and Biological Products and Specialties, as well as a number of interesting new items will be featured. Well informed Squibb Representatives will be on hand to welcome you and to furnish any information desired on the products displayed.

#### SURGICAL SUPPLY CO.

The Surgical Supply Company, a Florida organization with stores located in Jacksonville, Tampa, Miami, and Orlando, has an organization of thirty-five, including eight traveling representatives. Their line of general surgical, laboratory, and hospital supplies and equipment includes many items worthy of special mention. They are distributors of Baxter's Intravenous Solutions; Scanlan Morris Pressure Sterilizers; Multibeam Operating Lights; Balfour Tables; Burdick Physiotherapy equipment; Beck Lee Hindle Cardiographs; Hamilton professional furniture; genuine Stille Instruments, and many other items. This aggressive organization appreciates the opportunity to serve Florida's medical profession.

#### WESTINGHOUSE X-RAY COMPANY

Westinghouse X-Ray Company will have on display a modern Shockproof X-ray Unit, embodying the latest features; also, short wave generator and Westinghouse Bactericidal Lamp, which has been an outstanding contribution to the medical profession, particularly in the treatment of infectious type wounds. Be sure to see the new thin wall X-ray illuminator, in which the new fluorescent type lamps are used.

#### STATE NEWS ITEMS

The program of the Graduate Short Course to be held June 19-24 in Daytona Beach will be published in the next issue of the *Journal*. Only one application has been received up to the present for the proposed special course on Diseases of the Chest. Unless a sufficient number of registrations are received very shortly, this feature of the Short Course will have to be omitted. Registrations may be made through Dr. T. Z. Cason, 2033 Riverside Avenue, Jacksonville.

Dr. Carl S. Lytle of Dunnellon recently attended a medical meeting in Atlanta.

\* \* \*

A one and one-half ton iron lung was recently presented to the Jackson Memorial Hospital of Miami. This iron lung, the only one of its kind available for public use in south Florida, was accepted in behalf of the hospital by Dr. R. C. Woodard, superintendent; Dr. P. B. Welch, chief of staff; and Dr. Robert Spicer, representing the executive committee of the hospital. The iron lung was purchased by popular subscription in a campaign sponsored by the Harvey Seeds Post, American Legion, aided by the Dade County Infantile Paralysis Foundation.

\* \* \*

Dr. Grady H. Brantley was recently nominated mayor of Lake Worth. Doctor Brantley not only captured his own race, but also took with him every candidate on the Brantley-for-Mayor ticket.

\* \* \*

Dr. W. H. McCullagh of Jacksonville was one of the principal speakers at the Forum on Marriage and the Family held at the Snyder Memorial Church of that city on March 26. His subject was "Mental Hygiene and Personality Problems in Marriage."

\* \* \*

Dr. R. L. Sullivan served as delegate from the Pensacola chapter of the Woman's Benefit Association at a state convention held in Miami the first of April.

\* \* \*

Dr. M. A. Collier of Wauchula spent some time in Atlanta during March attending medical clinics at Grady Hospital.

\* \* \*

The next meeting of the International College of Surgeons will be held in New York City at the Roosevelt Hotel, May 21-25. Forty nations will be represented.

\* \* \*

The Florida doctors attending the Southeastern Surgical Congress in Atlanta, Georgia, March 6 to 9 inclusive, were: Drs. J. C. Davis, Quincy; F. D. Gray, Orlando; W. C. Roberts, Panama City; Ralph E. Stevens, Chattahoochee; J. Ralston Wells, Daytona Beach; and C. D. Whitaker, Marianna.



# 1 THE MOST IMPORTANT YEAR!

From the very beginning of "The Most Important Year," the infant requires a carefully balanced diet for the healthy development of bone and tissue structure.

Infants do well on S.M.A. because it is nutritionally correct. Not only is it essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, but equally important from a nutritional standpoint, it is also similar in other biological factors, especially in chemical constants of the fat and in physical properties.\*

The vitamin content of S.M.A. remains constant throughout the year. With the exception of orange juice no additional vitamin supplement need be given.

Use the coupon at the bottom of this page to send for S.M.A. A brief trial will show convincing proof of the efficacy of S.M.A. for infant feeding.

*\*S.M.A. is a food for infants — derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and in physical properties.*

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Please send samples of S.M.A. and a Minute-Mix Set to:

Dr. ....  
Street.....  
City..... State.....

Dr. R. N. Joyner of Marianna has resigned as health officer of Jackson County. Doctor Joyner will remain in Marianna to take up the practice of medicine.

\* \* \*

The dramas in the series of weekly radio programs by the American Medical Association and the National Broadcasting Company for May, which will deal with the general subject "Mothers and Children," have been announced as follows:

May 3—Healthier Babies.  
May 10—Healthier Mothers.  
May 17—The Doctor's Workshop.  
May 24—Toddlers, 1939.

This program is broadcast over the Blue network of N. B. C. each Wednesday at 2 p. m. *e. s. t.* \* \* \*

Dr. W. J. Williams announces the removal of his office from Seville to DeLand, where he will be located in the Fountain Building.

\* \* \*

Special transportation arrangements have been perfected for Florida members attending the annual meeting of the American Medical Association at St. Louis, May 15-19. Through sleeping cars for Florida members will leave Jacksonville on the *Dixie Limited*, 8:20 a. m., Saturday, May 13, arriving at St. Louis 11:43 a. m. Sunday, and on the *Dixie Flyer* leaving Jacksonville 9:00 p. m., the 13th, arriving at St. Louis early Monday morning.

Full information on rates and schedules are shown on page 480.

\* \* \*

Dr. J. H. Randolph of Jacksonville addressed the student body of Ruge Hall, Tallahassee, at their forum meeting on Christian Marriage, on March 24, discussing certain medical aspects of the subject. Preceding this forum, Dr. Sarah Parker White of the Florida State College for Women entertained Doctor Randolph at an informal supper and round table discussion of Steps for Development of a State Department of Mental Hygiene.

\* \* \*

Dr. J. Randolph Perdue of Miami attended a meeting of the South Atlantic Association of Obstetricians and Gynecologists in Charleston, S. C., February 10 and 11.

\* \* \*

The forty-fourth annual convention of the American Academy of Ophthalmology and

Otolaryngology will be held in Chicago October 8-13 at the Palmer House. About half the program will be devoted to formal addresses but fully half the week's activities will consist of "instructional courses," in which the doctors go to school in earnest, with hundreds of eminent specialists as their instructors.

#### DEATHS

Dr. Andrew P. Albaugh of Tarpon Springs died in Tarpon Springs on March 16.

\* \* \*

Dr. John F. Binkley of Palm Beach died March 22.

#### ANDREW PHILLIPS ALBAUGH

Dr. A. P. Albaugh, oldest practicing physician in Tarpon Springs, died Thursday, March 16, of cerebral hemorrhage.

Born June 23, 1862, at Kilgore, Ohio, Doctor Albaugh was the son of Peter and Mary Phillips Albaugh. He received his education at Ohio Northern and attended the Miami Medical College at Cincinnati, receiving his medical degree in 1887. The same year he was married to Adda Florence Roof and began his practice at Kilgore. Ten years later he brought his family to Tarpon Springs and was actively engaged in practice until a few days before his passing.

In 1905 Doctor Albaugh was appointed local observer for the weather bureau in which position he served with distinction, receiving special recognition from Washington for long and faithful service. He had held many other positions in civic life, having been president of the city council, member of the local school board, chairman of two Liberty Loan drives and, during the World War, chairman of the local Red Cross. At one time he also served as vice president of the Bank of Commerce.

Doctor Albaugh was a member of the American Medical Association, honorary member of the Florida Medical Association and the Pinellas County Medical Society. He was affiliated with the Trinity Methodist Church, the Masonic Lodge, the Knights of Pythias, and the Woodmen of the World.

Besides his widow, he is survived by a daughter, Mrs. Harold Lenfestey of Tampa; a son, Esten Albaugh of Tarpon Springs, and six grandchildren.





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JACKSONVILLE, FLORIDA

REGISTERED A. M. A.

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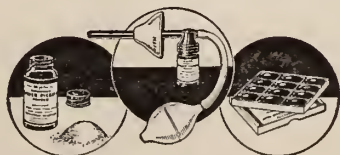
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## JOHN FREY BINKLEY

Dr. John F. Binkley of West Palm Beach died March 22 at the age of 51.

Doctor Binkley was born in Springville, Tenn., January 1, 1888, the son of the late Mr. and Mrs. John Binkley of an old Tennessee family. He received his medical education at Vanderbilt University, from which he graduated in 1917. He practiced at Nashville until thirteen years ago when he moved with his family to Florida. During the World War Doctor Binkley was a member of the American Floating Battalion, Medical Corps.

He was a member of the American Medical Association, the Southern Medical Association, the Florida Medical Association, and the Palm Beach County Medical Society. Other affiliations were with the First Presbyterian Church, Nashville, and the local Legion Post.

Survivors include his wife, Mrs. Adelaide Binkley; two daughters, Betty and Peggy; one son, John F. Binkley, Jr.; also five brothers and one sister of Nashville.

## COMPONENT COUNTY SOCIETIES

### BAY COUNTY MEDICAL SOCIETY

The Bay County Medical Society has joined the Honor Roll of 100% paid societies. This society, with a membership of 11 active and 1 honorary member, is headed by Dr. Donald S. Fraser, president; Dr. Amsie H. Lisenby, vice-president; and Dr. William C. Roberts, secretary-treasurer.

\* \* \*

### BREVARD COUNTY MEDICAL SOCIETY

At the annual meeting of the Brevard County Medical Society, the following officers were elected to serve for the current year: president, W. J. Creel, Eau Gallie; vice-president, I. F. Bean, Melbourne; secretary-treasurer, I. K. Hicks, Melbourne.

\* \* \*

### DADE COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Dade County Medical Society was held in the Sunshine Room of the Florida Power and Light Building, Tuesday evening, March 7 at 8:30 p. m. The president, Dr. M. Jay Flipse, presided. Dr. W. Henry Spiers, president of the State Association, was a guest of the society.

Following the business meeting, Dr. Jos. Stewart read a paper on "Intestinal Obstruction: A Presentation of Three Cases." This paper was discussed by Drs. Walter Jones, Jos. Lucinian, Hillard Willis, and A. G. Levin.

\* \* \*

### DE SOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society held its regular monthly meeting at the Simmons Hotel in Wauchula Tuesday evening, March 14. Dr. B. D. Spears, president of the organization, presided.

After the dinner, a scientific session was held at which Doctor Spears of Wauchula and Dr. C. E. Caylor of Bluffton, Ind., read interesting papers.

Present at the meeting were: Drs. G. H. McSwain, Arcadia; I. W. Chandler and G. S. McKnight, Avon Park; D. M. Draughn, Moore Haven; L. W. Martin and H. V. Weems, Sebring; M. A. Collier, M. C. Kayton, A. A. Poucher, and B. D. Spears, Wauchula; and C. E. Caylor, Bluffton, Ind., E. E. McPeck, Cleveland, Ohio, and B. F. Turner, Memphis, Tenn.

\* \* \*

### DUVAL COUNTY MEDICAL SOCIETY

The regular meeting of the Duval County Medical Society was held March 7 in the library of the State Board of Health Building. Dr. T. E. Buckman presided.

Dr. Ferdinand Richards was in charge of the scientific program. Dr. H. Marshall Taylor gave an interesting paper on "Otitis and Sinusitis in the Swimmer," with slides and moving pictures. Doctor Taylor gave evidence to show that man is a terrestrial animal and is anatomically and physiologically not suited to aquatic environment. He pointed out that all aquatic animals possess nasal passages and external auditory mechanism adapted to protecting the columnar ciliated epithelium and tympanic membrane. Man has but little protection against chilling as compared with marine animals and, as water takes up twenty-seven times the amount of heat from the body as is taken up by the atmosphere, the lower resistance to infection in the swimmer is not surprising. These facts, the doctor pointed out lead to the infections of the ears and sinuses.



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#### TAMPA

An interesting history of swimming was given and proper methods of diving and breathing while swimming were suggested.

A business meeting was held. Dr. Lillian C. Mark was voted into membership in the Society. Doctor Mark is doing general practice in Jacksonville. Following the meeting, refreshments were served.

\* \* \*

#### FRANKLIN-GULF COUNTY MEDICAL SOCIETY

The Franklin-Gulf County Medical Society held a meeting at Apalachicola Thursday evening, March 23. Dr. A. E. Conter, host to the society, entertained at dinner at the Gibson Hotel.

\* \* \*

#### MARION COUNTY MEDICAL SOCIETY

The Marion County Medical Society, as usual, is among the first to join the Honor Roll of 100% paid societies. Serving as officers of the society are: Drs. Carl S. Lytle, president; J. L. Strange, vice-president; and R. C. Cumming, secretary-treasurer.

\* \* \*

#### MONROE COUNTY MEDICAL SOCIETY

Dr. William R. Warren, for many years secretary of the Monroe County Medical Society has forwarded the roster of the society and remitted 100 per cent of dues for 1939. Dr. Harry C. Galey is president of the society and Dr. Julio J. De Poo is vice-president. Congratulations!

\* \* \*

#### PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. George A. Dame entertained the Pasco-Hernando-Citrus County Medical Society in Inverness, Thursday evening, March 9. Dinner was served at Mrs. Jones' Cafe, followed by a meeting in Doctor Dame's office.

The minutes of the last meeting were read and adopted. A motion was made and carried that the new Constitution and By-Laws be adopted and that the Pasco-Hernando-Citrus County Medical Society be incorporated. The Board of Trustees was requested to proceed with the proper legal procedure to incorporate the society.

Interesting case reports were given by Drs. P. J. Hudson, S. C. Harvard and George A. Dame. Those present were: Drs. C. L. Carter, G. R. Creekmore, George A. Dame, H. L.

Harrell, S. C. Harvard, P. J. Hudson, W. W. Jones, David B. Manley, W. B. Moon, and W. H. Walters. Dr. Carl S. Lytle, president of the Marion County Medical Society, was an invited guest.

Dr. Wardlaw Jones invited the Society to hold its next meeting with him in Dade City. There being no further business, the meeting adjourned.

\* \* \*

#### PINELLAS COUNTY MEDICAL SOCIETY

The first bi-weekly meeting of the Pinellas County Medical Society was held at the Chatterbox on the evening of March 3. Dr. Edward Christopher Brenner of New York City, Associate Professor of Clinical Surgery, Columbia University Graduate School of Medicine, was principal speaker. He discussed "Tumors and Tumefactions of the Head and Neck in Children."

The second meeting during March was also held at the Chatterbox, Friday evening, March 17. At this meeting Dr. O. N. Nelson of Bay Pines presented a paper on "Anaphylaxis and Allergy."

\* \* \*

#### POLK COUNTY MEDICAL SOCIETY

The Polk County Medical Society has the distinction of being the largest society in Florida which has reported 100% of dues for 1939. This society has a membership of 62, headed this year by Dr. John F. Wilson, president; Dr. D. Paul Bird, vice-president; and Dr. J. R. Boulware, Jr., secretary-treasurer. Congratulations!

The monthly meeting of the Polk County Medical Society was held in Bartow on the evening of March 9 at the Civic Center.

During the business session, the following delegates and alternates were chosen to represent the society at the coming meeting of the State Association: delegates, Drs. J. R. Boulware, R. L. Cline, and R. L. Hughes; alternates, Drs. Herman Watson, J. L. Hargrove, and C. W. Pease.

The president, Dr. J. F. Wilson of Lakeland, presided over the meeting and introduced Dr. J. B. Modisette who read a paper on "The Relationship of the Body and Mind." A round table discussion on "Syphilis" was led by Drs. R. L. Hughes, W. F. Peacock, and C. W. Pease. Dr. J. L. Hargrove sent in



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**OBSTETRICS**—Two Weeks' Intensive Course June 19 and October 23. Informal Course every week.

**FRACTURES AND TRAUMATIC SURGERY**—Ten-Day Formal Course, June 19 and September 25. Informal Course every week.

**OTOLARYNGOLOGY**—Two Weeks' Intensive Course starting September 11. Informal Course every week.

**OPHTHALMOLOGY**—Two Weeks' Intensive Course starting September 25. Informal Course every week.

**CYSTOSCOPY**—Ten-Day Practical Course rotary every two weeks.

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a statistical report of the incidence of syphilis among patients in the county hospital.

Following a general discussion, the society adjourned to meet in Lakeland in April.

\* \* \*

#### PUTNAM COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Putnam County Medical Society was held Tuesday evening, March 14, at the Marion Hotel, Palatka. The meeting was devoted to a discussion of contagious diseases prevalent in Putnam County and plans for the institution of preventive measures were formulated.

Those present were: Drs. E. W. Ford and J. E. Rose of Crescent City; F. Emory Bell, C. M. Knight, A. P. Gurganious and G. M. Zeagler of Palatka.

\* \* \*

#### ST. JOHNS COUNTY MEDICAL SOCIETY

The St. Johns County Medical Society has paid its entire assessment of 1939 dues. This society has a membership of ten and is officered by Drs. R. D. Harris, president; Charles C. Grace, vice-president; G. Walter Potter, secretary; and A. C. Walkup, treasurer.

\* \* \*

#### ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY

The St. Lucie-Okeechobee-Indian River-Martin County Medical Society is a 100% paid society. This society has a membership of sixteen active and one honorary members. Officers are: Drs. J. D. Parker, president; F. A. Gowdy, vice-president; and A. M. Sample, secretary-treasurer.

\* \* \*

#### MEDICAL DISTRICT MEETINGS 1939



Marianna (A) . . . . . July 21  
Palatka (C) . . . . . Sept. 15  
Lakeland (D) . . . . . Sept. 29  
West Palm Beach (F) Oct. 13  
Ocala (B) . . . . . Oct. 27  
Sanford (E) . . . . . Nov. 10

Any member who wishes to read a scientific paper at his district meeting is urged to make application immediately. From applications received four essayists will be selected by the senior councilor in each district. Mail your applications to Box 1018, Jacksonville, Florida.



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## ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

**Penetrating Wounds of the Heart: Report of Two Cases, MORRIS, KENNETH A., Jacksonville, Am. J. Surg. 41: 103-111 (July), 1938.**

The author reports two cases of penetrating wounds of the heart. One patient recovered after operation and suture; the second died during the operation. Suture of the wound was unsuccessful because of advanced myocardial degeneration. In each instance aspiration of blood from the pericardium was used to relieve the tamponade so that the patients could be brought to operation. The danger of the heart tamponade due to hemorrhage inside the pericardial sac is emphasized, as well as the advisability of aspiration as a temporary life-saving measure before operation. The final paragraph sums up the most important factor in successful surgery of these wounds:

"If the house surgeon or the physician who first sees the patient suspects heart wounds in all lacerations of the chest and knows the signs of heart tamponade, the percentage of recoveries will undoubtedly be increased."

**Some Experiences with the Flexible Gastroscope, BORLAND, J. L., Jacksonville, South. Surgeon 7: 385 (Oct.), 1938.**

Neither the gastroscope nor the x-ray is able to visualize the entire stomach. However, the areas not visible by gastroscopy which include the proximal portion of the lesser curvature (obscured by the angulus), a small area on the posterior wall at the greater curvature, an area of varying size on the posterior wall close to the lesser curvature just at the cardia, and the superior mesial margin of the fornix, are areas in which x-ray is most certain.

Borland believes that "gastroscopy will survive, regardless of future developments, if for no other reason than that it offers a means of diagnosis of early gastric cancer."

An interesting light is thrown on the subject of gastric hemorrhage with the author's observation that marked gastric hemorrhage may be produced by relatively simple inflammatory gastric lesions, such as gastritis without ulcer, carcinoma or varices.

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**10 lbs.**

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10 measures HYLAC

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12 measures HYLAC

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**NEWS FROM DUVAL COUNTY**

The Woman's Auxiliary to the Duval County Medical Society has been very active this year under the wise leadership of Mrs. F. W. Krueger, President. The Philanthropic Chairman, Mrs. Eugene Simmons, and her committee collected samples of medicine from the offices of all the doctors of Duval County and gave to Brewster Hospital for the colored. A letter of acknowledgment from the superintendent gave evidence of the deep appreciation felt by the Hospital for this useful gift.

Dr. A. B. McCreary gave a splendid talk at the Fall meeting of the Duval County Health Unit which has been recently organized. He told of the great need for a Health Unit and mentioned a number of things which has been accomplished by other county health units throughout the state and outlined what he felt could be accomplished in Duval County to improve health conditions and which he thought would solve many of our health problems.

Dr. Dan Funkenstein gave an illustrated lecture with slides on Plastic Surgery at the March meeting. A round table discussion followed which proved very interesting and instructive.

The Auxiliary cooperated with the Red Cross and with the sale of the Tuberculosis seals again this year with gratifying results. Their contributions to the Happy Hearts Club and the Community Chest deserve honorable mention.

A Health Institute was planned early in the year which was held in the auditorium of the State Board of Health on April 5, from 2 until 4:30 p. m.

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There were six speakers. A lecture on cancer was given in cooperation with Mrs. J. Ralston Wells of the Women's Field Army of the American Society for the Prevention of Cancer. Wax models from the United States Health Department, showing the effect of cancer on different parts of the body were on exhibit. Most of these lectures were illustrated with slides.

Too much credit cannot be given Mrs. O. P. Broadbent for her untiring efforts in planning the Health Institute and the splendid publicity she gave it. The Auxiliary is also grateful to Mrs. W. L. Dinning, state publicity chairman of the Women's Field Army of the American Society for the Prevention of Cancer, for her assistance in giving the Health Institute wide publicity.

A large delegation is expected to attend the State Medical Meeting in Daytona Beach, May 1, 2, and 3, 1939.

### BOOKS RECEIVED

OUR COMMON AILMENT. Constipation: Its Cause and Cure. By HAROLD AARON, M.D., Medical Consultant to Consumers Union of U. S., Inc.

This book explains to laymen the nature and cause of constipation. It turns the searchlight on most of the well known drugs and remedies which people, on the strength of patent medicine advertisements, pour into their systems. Also discussed are "roughage," high and low enemas, colitis and hemorrhoids. Cloth, pp. 192; price, \$1.50. New York. Dodge Publishing Company.

### ATTENTION TO ADVERTISEMENTS

The fact has often been mentioned that income from advertisements forms the backbone for the existence of any publication. This is as true for medical as other magazines. One form of advertising appeals particularly to the reader, in which the advertiser seeks personal contact with him by means of the coupon which one is requested to detach and mail to a given address. The advertiser usually has samples of his products which will be distributed to all inquirers making use of the coupon. If the reader will pay attention to these and utilize them as requested, the interest thus displayed will be advantageous in promoting the well-being of the journal in which he is personally interested.



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Districts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Marianna July 21, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	12	100%
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. DeSoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	31
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. B. Spire, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Ramsey, M.D. Noma	L. H. Paul, M.D. Bonifay		Santa Rosa	8	7
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'39 N. A. Baltzell, M.D. Marianna	6	100%
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		14	12
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	37	27
North Central District (B) Ocala October 27, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M.D. Lake City	20	14
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Ralph J. Greene, M.D. Perry	W. J. Baker, M.D. Foley	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton-Lafayette-Suwannee	8	6
	Alachua	J. E. Malnes, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St. S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	28	21
	Marion	Carl S. Lott, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		22	100%
	Pasco-Hernando-Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	14
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	Bradford-Gilchrist-Levy-Union	3	2
N. E. District (C) Palatka September 15, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M.D. Jacksonville	172	165
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	10	9
	Volusia	Maximilian Stern, M.D. Box 5098 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	41	37
	Hillsborough	J. W. Alsobrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M.D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M.D. Plant City	107	76
	Manatee	S. G. Hollingsworth, M.D. Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.		15	100%
	Pinellas	E. C. MacCordy, M.D. 627 11th St. N. St. Petersburg	W. C. McConnell, M.D. 1005 Equitable Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		89	100%
Southwest District (D) Lakeland September 29, 1939	Sarasota	T. W. Taylor, M.D. Walpole Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	10
	DeSoto-Hardee-Highlands-Charlotte-Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M.D. Lakeland	19	100%
	Lee	C. Gordon Myrick, M.D. 26 Leon Bldg. Fort Myers	H. L. Allan, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		14	11
	Polk	John F. Willson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	61	100%
	Brevard	W. J. Creel, M.D. Eau Gallie	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	11	7
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	13
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		77	67
South Central District (E) Sanford November 10, 1939	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M.D. Ft. Pierce	17	100%
	Broward	R. L. Elliston, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Ft. Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	33	100%
	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Harvey Bldg. W. Palm Beach	4th Monday 8:00 P. M.		58	47
	Dade	M. Jay Flipse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M.D. Miami Beach	290	177
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	100%
S. E. District (F) West Palm Beach October 13, 1939							



STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	W. Henry Spiers, Orlando.....	Shaler Richardson, Jacksonville....	Daytona Beach, May 1, 2, 3, 1939
Florida Medical Districts:			
—Northwest .....	Carol C. Webb, Pensacola.....	Stewart Thompson, Jacksonville...	Marianna, July 21, 1939
—North Central .....	J. L. Strange, McIntosh.....	" " "	Ocala, Oct. 27, 1939
—Northeast .....	George M. Green, Daytona Beach.....	" " "	Palatka, Sept. 15, 1939
—Southwest .....	Herman Watson, Lakeland.....	" " "	Lakeland, Sept. 29, 1939
—South Central .....	W. C. Page, Cocoa.....	" " "	Sanford, Nov. 10, 1939
—Southeast .....	Lloyd J. Netto, West Palm Beach.....	" " "	West Palm Beach, Oct. 13, 1939
Alabama Medical Association.....	Seale Harris, Montgomery.....	D. L. Cannon, Montgomery.....	Montgomery, Apr. 18-20, 1939
Georgia Medical Association.....	Grady N. Coker, Canton.....	E. D. Shanks, Atlanta.....	Atlanta, April 25-28, 1939.
Idaho—			
Iowa Dental Association.....	R. P. Taylor, Jacksonville.....	E. C. Lunsford, Miami.....	West Palm Beach, Oct. 12-14, 1939
Assoc. of Derm. and Syph.....	Elmo D. French, Miami.....	Lauren Sompayrac, Jacksonville....	Tampa, May 1, 1939
East Coast Medical Association.....	Frederick J. Waas, Jacksonville.....	A. J. Logie, Jacksonville.....	Jacksonville, 1939
Iowa Hospital Association.....	J. H. Therrell, Chattahoochee.....	Mr. Fred Walker, Jacksonville.....	
Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville.....	Chairman	Daytona Beach, June 19-24, 1939
Iowa Nurses Association.....	Mrs. Inez Nelson, Orlando.....	Mrs. Phyllis Leonard, St. Augustine	Lakeland, Nov. 6-8, 1939
Pediatric Society .....	Gilbert S. Osincup, Orlando.....	Warren Quillian, Coral Gables.....	Daytona Beach, May 1, 1939
Pharmaceutical Association .....	Mr. R. Q. Richards, Ft. Myers.....	Mr. A. W. Morrison, Miami.....	Hollywood Beach, May, 1939
Public Health Association .....	Mr. S. D. Macready, W. P. Beach.....	E. M. L'Engle, Jacksonville.....	Jacksonville, 1939
Radiological Society .....	H. O. Brown, Tampa.....	J. H. Lucinian, Miami.....	Daytona Beach, May 1, 1939
Railway Surgeons Association.....	Herman Watson, Lakeland.....	H. D. Clark, Ft. Pierce.....	Daytona Beach, May 1, 1939
Tuberculosis & Health Assn.....	Mr. G. E. Therry, W. Palm Beach.....	Mrs. May Pynchon, Jacksonville....	Spring, 1939
Chattahoochee Valley Med. Assn.....	J. S. Turberville, Century.....	Frank K. Boland, Atlanta.....	Albany, Ga., July 11-13, 1939
East Coast Clinical Society.....	J. H. Dodson, Mobile.....	C. C. Rouse, Mobile, Ala.....	Mobile, 1939
Eastern Derm. Assn.....	J. R. Allison, Columbia.....	Howard King, Nashville.....	Nashville, Sept. 3, 1939
Eastern Surgical Congress.....	R. L. Sanders, Memphis, Tenn.....	B. T. Beasley, Atlanta.....	Birmingham, Mar. 11-13, 1940
Western Medical Association.....	W. E. Vest, Huntington, W. Va.....	Mr. C. P. Loranz, Birmingham.....	Memphis, Nov. 21-24, 1939
Yankee River Medical Society.....	E. C. Chamberlain, Madison.....	Eustace Long, Madison.....	

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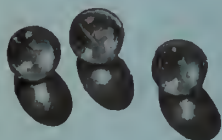


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American Medical Association, St. Louis, May 15-19, 1939  
Florida Medical Association, Tampa, 1940  
Southern Medical Association, Oklahoma City, November 15-18, 1938

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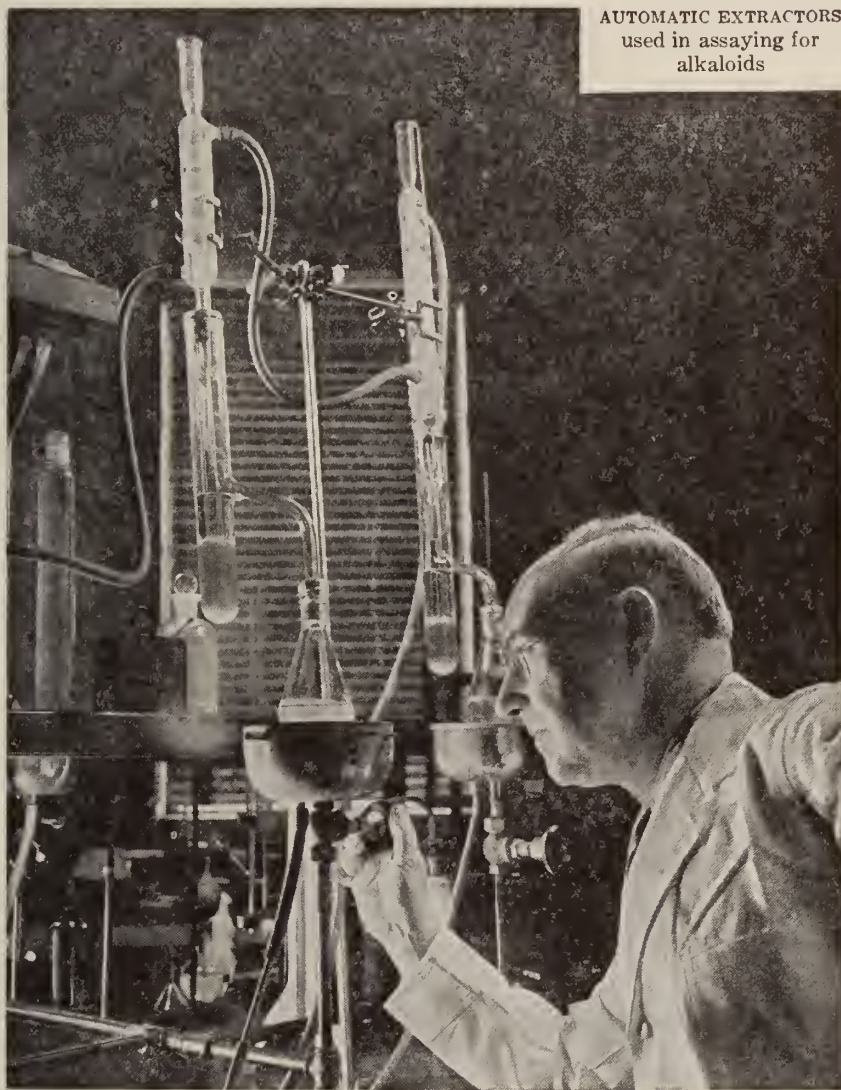


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## THE "SURGICAL KIDNEY" IN OBSTETRICS

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Clinical evidence of the small amount of renal tissue necessary to sustain life constantly presents itself. It is not surprising, therefore, that the pregnant patient who exhibits a serious surgical lesion of one or both kidneys, or who has previously undergone extensive surgery of the upper urinary tract, is frequently able to carry the pregnancy to a successful conclusion. Therapeutic abortion should not be advised on the basis of the renal lesion present, unless and until a complete urologic study demonstrates renal insufficiency not amenable to treatment. In each of the four cases here reported the patient had been advised by one or more physicians to have the pregnancy interrupted. In all of them, how-



Fig. 1.—Preliminary roentgenogram; bilateral massive nephrolithiasis. Pregnancy at the fourth month. Calcified glands, right.

ever, a study of the urinary tract demonstrated fair to good renal function, and a conference between the obstetrician, the urologist and the internist, in collaboration with the roentgenologist and the pathologist, led to the decision to adhere to conservative treatment.

## MASSIVE BILATERAL NEPHROLITHIASIS

Cases of renal calculi, even without much obstruction or infection, and particularly if bilateral and massive, are often thought to demand the interruption of pregnancy. On the contrary, these cases may go past viability or even to full term without open surgery on either kidney. The following case serves as an illustration.



Fig. 2.—Uretero-pyelogram confirming diagnosis of bilateral massive nephrolithiasis. Note stag-horn calculus filling pelvis and calices of left kidney and large calculus in pelvis of right kidney. Poor drainage at left uretero-pelvic juncture.

CASE 1.—Mrs. S. B., white, aged 22 years, was four months pregnant and complained of frequency of urination, burning at urination and pain across the back when she was referred to me in February, 1933, by Drs. S. R. Norris and T. S. Field. Attacks of frequency of urination, dysuria and burning at urination, accompanied by an elevation of temperature and at times nausea but no vomiting, and lasting from a few days to a week, had recurred intermittently for two years, she said; since the onset of pregnancy, pain across the back had developed. In the course of previous examinations, urinalysis had revealed pyuria, and a roentgen study of the urinary tract had disclosed the presence of a large calculus in the pelvis of each kidney (Figure 1).

Cystoscopic examination revealed that the bladder was displaced upward and forward by the large pregnant uterus. Analysis of a specimen of urine from the bladder showed pus cells and albumin 2 plus and erythrocytes 1 plus; in the specimens from the kidneys the albumin was 1 plus, and there were a few pus cells and erythrocytes in each. Phenolsulphonphthalein appeared in 12½ minutes on the right side and 8 minutes on the left, the output in 30 minutes being 18 and 14 per cent respectively. Cultures revealed the presence of *Staphylococcus aureus* in the left kidney. Analysis of the blood chemistry showed urea nitrogen 28 mg. and creatine 1.5 mg. per 100 cc. of blood; acetone was negative.

Confirming the preliminary roentgen study, pyelograms revealed a large calculus occupying the pelvis of the right kidney and a branched calculus filling the pelvis and calices of the left kidney, with poor drainage at the left uretero-pelvic juncture (Figure 2).

During the interim before delivery, the renal infection was partially controlled by fluids, drugs and repeated pelvic lavage. The patient's blood pressure was elevated, and there was some toxemia. On July 19, in the eighth month of pregnancy, labor was induced, and a normal child was delivered (Figure 3).

Six months later, on Jan. 24, 1934, a pelvolithotomy was done on the right side, and a calculus  $1\frac{1}{2}$  by 1 by 1 inches in size was removed. On May 8, a pelvolithotomy was done on the left side, and a stag-horn



Fig. 3.—Child, aged 5 years, 8 months, born one month prematurely to patient with bilateral massive nephrolithiasis.

calculus 2 by  $1\frac{1}{2}$  by 1 inches in dimension was removed. The patient discontinued treatment in October of that year. When she returned in April, 1936, eighteen months later, there was profuse pyuria, and a recurrent massive calculus in the left kidney (Figure 4). Thereafter she submitted to treatment regularly, and on October 5 a nephrolithotomy was performed on the left side. Renal drainage and lavage were then carried out every week for the first year and every two weeks for the second year. In October, 1938, the patient had no pyuria, no calculi were present, and cultures were sterile (Figure 5).



Fig. 4.—Preliminary roentgenogram: recurrent massive calculus, left, two years after pelvolithotomy.

#### POSTNEPHRECTOMY AND PELVOLITHOTOMY ON REMAINING KIDNEY

Nephrectomized patients stand surgery and other illness successfully. Owing to increased functional activity, the remaining kidney undergoes compensatory hypertrophy and is able to make a normal recovery following an operation on itself. If there develops a pregnancy, this single kidney, previously operated upon, may function properly with safety both to the mother and the child. Case 2 is illustrative.

CASE 2.—Mrs. S. R., white, aged 36 years, was sent to me by Dr. T. S. Field in June, 1936. She complained of the absence of menstruation for two periods. Her history was usual except for a nephrectomy on the right side for multiple calculi some years previously and, later, a pelvolithotomy on the left side for a large calculus. She stated that she had been married seven years, had not been pregnant and had used no contraceptives.

The physical examination revealed that she was two months pregnant, and there was a fibroid tumor of the uterus, posterior in position and about 2 inches in diameter. The bladder was normal, and there was no obstruction of the left ureter. Urinalysis was essentially negative. Phenolsulphonphthalein appeared in 6 minutes on the left side, and the output was 30 per cent for the first hour and 20 per cent for the second. Cultures gave only negative results. Analysis of the blood chemistry showed urea nitrogen 15 mg., creatine 1.4 mg. and nonprotein nitrogen 30 mg. per 100 cc. of blood; acetone was negative.

Roentgenologic examination disclosed the presence of several calculi at the stump of the right ureter (Figure 6), but there was no stone in the region of the left kidney. A pyelogram of the left side revealed a large single kidney, also hydronephrosis (Figure 6).

The pregnancy progressed to full term without complications, and on Jan. 18, 1937, a normal infant was delivered by cesarean section (Figure 7). Cystoscopy followed, and an indwelling catheter was placed in the left ureter and renal pelvis.

After delivery, the patient suffered from intermittent pyuria. When she was examined in October, 1938, there was no roentgenologic evidence of a stone in the region of the left kidney, but slight hydronephrosis was indicated in the pyelogram (Figure 8); there was no evidence of pyuria; in the phenolsulphonphthalein test



the output was 25 per cent for the first hour and 20 per cent for the second, and analysis of the blood chemistry showed nonprotein nitrogen 37.5 mg. per 100 cc. of blood.

#### UNILATERAL PYELONEPHRITIS AND MULTIPLE NEPHROLITHIASIS

The type of infection present in the surgical kidney may indicate the procedure to be determined upon in pregnancy, particularly when there is renal obstruction. Constitutional symptoms, chills, fever, loss of weight and anemia add to the seriousness of this syndrome. Often it is dangerous to wait, dangerous to drain



Fig. 5.—Roentgenogram, October, 1938, two years after nephrolithotomy, left, had been performed because of recurrent massive calculus. No recurrent calculus.

and dangerous to abort. Moreover, in such cases, surgical drainage may precipitate abortion, or the therapeutic abortion may not relieve the renal obstruction. Should labor follow surgical drainage, the baby is usually lost, as was true in case 3.

CASE 3.—Mrs. E. S., a white quadripara, aged 26 years, was six months pregnant in July, 1938, when she was referred to me by Dr. A. D. Stollenwerck. She complained of pain in the left side, chills, fever and sweats. She stated that at intervals since the onset of this pregnancy, and for some months previously, she had had attacks of pain in the left loin, accompanied by chills, fever, anorexia, nausea, burning at urination and cloudiness of the urine. She had lost fifteen pounds in weight.

On examination, the patient's temperature was 102 F., the pulse rate 120 and respiration 20; there was a tender palpable mass in the region of the left kidney. Urinalysis showed pus cells 3 plus, albumin 3 plus and acetone 2 plus. Examination of the blood gave no evidence of malarial parasites, but disclosed a secondary anemia. Cystoscopy revealed that the bladder was situated high behind the pubes. Pus cells were 2 plus in specimens from both kidneys, and in the one from the right kidney erythrocytes were 1 plus. Cultures demonstrated the presence of *Bacillus coli* in the right kidney. Phenolsulphonphthalein appeared in 12 minutes on the right side with an output of 40 per cent in one hour; it did not appear on the left side. Analysis of the blood chemistry showed urea nitrogen 13 mg. and sugar 60 mg. per 100 cc. of blood; there was a trace of acetone.

A roentgen study revealed on the left side multiple nephrolithiasis (Figure 9), pyonephrosis and an obstruction at the uretero-pelvic juncture completely blocking the kidney (Figure 10). Hydronephrosis was discernible on the right side.

On July 25, 1938, a nephrostomy was done on the left side, under avertin administered rectally and novocain used locally. More than 250 cc. of pus was drained from the kidney. The following day, a premature infant, that lived but a few hours, was delivered.

A blood transfusion was given on August 10. Ten days later a nephrectomy was done on the left side. The pathologic findings were multiple nephrolithiasis, chronic pyelonephritis and pyonephrosis. The illness followed a prolonged septic course, and the patient was given blood transfusions on August 25, and on September 14 and 23. She was discharged on October 10. The incision healed, and in January, 1939, she had gained 25 pounds.

#### DESTRUCTIVE PYONEPHROSIS AND OBSTRUCTIVE NEPHROLITHIASIS WITH OPPOSITE HYDRONEPHROSIS

Renal lesions of long standing resulting in obstructive pyonephrosis lead to a unilateral loss of renal function. If the opposite kidney is hydronephrotic and the patient is approach-



Fig. 6.—Roentgenogram showing hypertrophy with hydronephrosis but no calculi in left kidney of nephrectomized patient two months pregnant. Calculi in stump of right ureter.

ing 40 years of age, the problem is doubly complicated. Close cooperation between the urologic surgeon and the obstetrician is essential for indwelling catheter drainage of the hydronephrotic kidney offers a hazard that constantly threatens to induce labor, and open drainage of the pyonephrosis doubles the hazard. Prolonged drainage is as a rule necessary, and hospitalization for many weeks or even months may be required. These conditions are illustrated in case 4.



Fig. 7.—Child, aged 2 years, 2 months, delivered at full term by cesarean section to nephrectomized patient with hydronephrosis of remaining kidney.

CASE 4.—Mrs. T. H., aged 38 years, a white tripara about five months pregnant, complained of pain in the right side and chronic kidney colic on the left side when she was sent to me in May, 1938, by Dr. E. T. Sellers. She related that she had suffered from attacks of kidney colic on the left side for fourteen years and had passed some thirty stones; hematuria had occurred numerous times, and for three years immediately preceding, pain in the right loin had persisted. The last menstrual period had occurred in December, 1937, she said, but there had been "a show" in January; hematuria had been present once in April, and the urine had been turbid most of the time since the onset of pregnancy. At the time of consultation she was suffering from backache, chills and fever at irregular intervals, anorexia and loss of weight.

Examination of the blood revealed a secondary anemia. Cystoscopy showed that the bladder was displaced upward and forward by the pregnant uterus. Four

ounces of clear urine were recovered from the right kidney and some turbid fluid from the left. Urinalysis showed pus cells 2 plus for the bladder and 3 plus for the left kidney; albumin was 2 plus for the bladder, 1 plus for the right kidney and 3 plus for the left kidney.



Fig. 8.—Uretero-pyelogram showing only slight hydronephrosis remaining in left kidney of nephrectomized patient, twenty-two months after delivery of normal child at full term by cesarean section (Fig. 7).

Cultures from the bladder and specimens from the left kidney revealed the presence of *Staphylococcus albus*. Phenolsulphonpthalein appeared in 4 minutes on the



right side, and the output in one hour was 60 per cent; it appeared in 20 minutes on the left side, but there was no output within one hour. Analysis of the blood chemistry showed urea nitrogen 17 mg. per 100 cc. of blood, and there was no evidence of acetone.

A large round dense calculus obstructing the pelvis of the left kidney was demonstrated reontgenologically (Figure 11). Pyelograms indicated hydronephrosis on



Fig. 9.—Roentgenogram; multiple nephrolithiasis, left.

the right side and nephrolithiasis and massive pyonephrosis on the left side (Figure 11).

To relieve the hydronephrosis, an indwelling catheter was placed in the right ureter. Under local anesthesia nephrostomy and nephrolithotomy were performed on the left side. The nephrostomy tube was left in place until after delivery four months later.



Fig. 10.—Pyelogram showing multiple nephrolithiasis, acute suppurative pyelonephritis and obstructive pyonephritis of left kidney in patient six months pregnant. Hydronephrosis, right.

On Sept. 4, 1938, during the eighth month of pregnancy, a normal infant, weighing 9½ pounds, was delivered normally (Figure 12). The patient's recovery progressed, and the nephrostomy was closed. Two weeks postpartum, bilateral hydronephrosis was shown in pye-

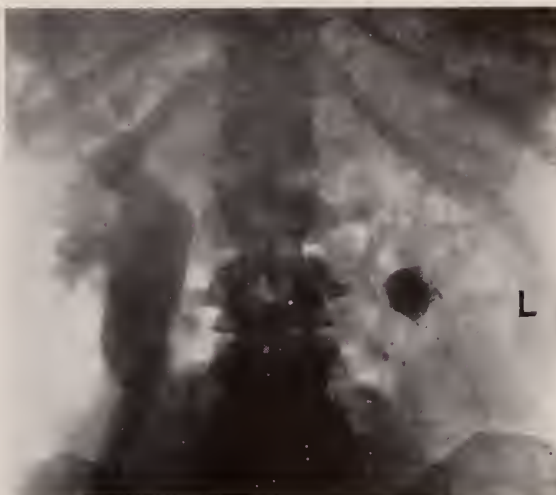


Fig. 11.—Roentgenogram; hydronephrosis, right (120 cc.), obstructive nephrolithiasis and destructive massive pyonephrosis, left. Pregnancy at about the fifth month.

lograms (Figure 13). *Bacillus coli* was present in all cultures. Pus cells were 1 plus in specimens from the bladder and 2 plus in specimens from the left kidney; the amount excreted by the right kidney was 45 cc. and by the left 100 cc. Phenosulphonphthalein appeared on the right side in 3½ minutes and on the left in 5½ minutes; the output for the right kidney was 65 per cent but it was scant for the left kidney. The blood chemistry was normal.

Despite catheter drainage of the renal pelvis at intervals, pyonephrosis recurred on the left side, and a nephrectomy was performed Nov. 21, 1938. Since that time the patient has remained well.



Fig. 12.—Child, aged 3½ months, delivered normally one month prematurely to patient with indwelling catheter in right ureter and nephrostomy tube still in place after nephrostomy and nephrolithotomy, left, performed four months previously.



Fig. 13.—Pyelogram; two weeks postpartum, bilateral hydronephrosis.

#### SUMMARY

A surgical lesion of one or both kidneys does not of itself indicate therapeutic abortion.

The decision to continue or to interrupt pregnancy in a patient with renal involvement should be reached only after a complete study of the case has been made.

Four cases of pregnancy complicated by the so-called "surgical kidney," carried to normal or operative delivery, with four living mothers and three living children, are here presented.\*

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\*From the Department of Urology, St. Vincent's Hospital, Jacksonville, Fla. The final operation in Case 1 was performed in St. Luke's Hospital, Jacksonville, Fla. The roentgenologic studies in the four cases reported were made by Dr. W. McL. Shaw. Drs. C. E. Royce and L. Y. Dyrenforth made the laboratory studies.

### TREATMENT OF CHRONIC PROSTATITIS BY INJECTION

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The purpose of this paper is to bring to your attention a method of treating cases of chronic prostatitis which have failed to respond to the methods usually employed. The treatment of chronic prostatitis is usually a prolonged affair and is often unsatisfactory even in spite of persistent therapy. Even though symptomatic relief is usually obtained after a period of prostatic massage and dilations, the prostatic secretion will often continue to show pus. In view of the great im-

portance of the infected prostate as a focus of systemic infection in these cases, it is important that the infection be completely eradicated, if possible. To that end, a consideration of the injection treatment of prostatitis is worthy of our attention.

Forty-three years ago Hoffman obtained good results from the injection of antiseptics into the prostate by perineal puncture. He used a 3 per cent phenol solution introduced through a long cannula inserted into the prostate through the rectum or perineum. In 1910 and 1913 Cano published the results of his observations with intra-prostatic injections of antiseptics. His methods were brought to the attention of Townsend and Valentine and in 1917 they published in conjunction with him the clinical results following 67 intra-prostatic injections of a phenol solution. Since this publication, Townsend has administered more than 1,000 intraprostatic injections without complications. This method of treatment of prostatic infections was not widely adopted and very little is mentioned in the literature about it until the recent publications by Grant. McCarthy in 1935 recommended the direct injection of antiseptics into the prostate through the panendoscope.

Previous to the work of O'Connor and Ladd, no mention is made in the literature regarding the changes that occur in prostatic tissue after it has been infiltrated with mercurochrome or colloidal silver. Grant states that at the beginning of his work he "injected a few dogs' prostates and they seemed none the worse." O'Connor and Ladd injected mercurochrome and colloidal silver solution into the prostates of fully grown dogs and found that this caused a chronic inflammatory reaction with scattered areas of necrosis with complete or partial destruction of acini. The late result was a diffuse fibrosis of the gland. From these experimental studies it would seem that the beneficial clinical results credited to intraprostatic injections must be due to the fibrotic obliteration of infected acini, rather than to localized sterilization of infected tissues.

In a later experimental study on dogs by O'Connor and Ladd, they injected the prostates of 32 dogs, using normal saline, 5 per cent neosilvol, 1:5000 tincture of metaphen,

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sterile distilled water, 2 per cent mercurochrome, isotonic electrargol, and finally some of the prostates were simply needled without injecting anything. It was found that the trauma of simple needling of the prostate was followed by an inflammatory reaction with considerable subsequent fibrosis and glandular destruction. The various solutions injected resulted in rather uniform changes that varied only in degree. The studies seemed to show that any solution injected into the prostate, whether normal saline, distilled water, or antiseptics, results in marked destruction of acini and chronic inflammatory changes with fibrosis.

From these experimental studies one cannot help but wonder whether the end result in some of these cases will not ultimately be a firm scarred prostate with a fibrous median bar obstructing the bladder neck. While a certain percentage of these patients with chronic prostatitis are apt to develop a fibrous median bar regardless of treatment, it is possible that intraprostatic injections might hasten the process by several years. This, to me, is the only real criticism of this form of treatment. However, to date there have been no studies to confirm or disprove such impressions.

To determine what became of substances injected into the prostate, Townsend injected India ink into obstructing adenomatous prostates immediately prior to enucleation. The enucleated adenomas were then sectioned and examined.

"The dye was found distributed irregularly in the tissue, some pigment granules within the lumen of the gland, as well as in the epithelia, some within the blood vessels, involving all the coats, and the remainder haphazardly scattered throughout the various structures, fibrous connective tissue and smooth muscle fibers, partly in large conglomerate masses." Since adenomatous prostates do not show the true character of dissemination of dyes because the proportion of glandular and fibrous tissue is changed, the prostate of a 20-year old criminal was injected 5 minutes after electrocution with 30 cc. of a 20 per cent suspension of India ink. Immediately thereafter the prostate and bladder neck were removed, sectioned and stained. These sections showed the presence of diffuse black pigment

in all tissues, connective, muscular, glandular and vascular. Therefore, it is apparent that substances thus injected into the prostate do diffuse throughout the gland, not only because of the local circulation but also because of the constant elastic pressure of the prostatic capsule. Townsend warns against the injection of any medication that cannot be tolerated by the general circulation, since these substances do find their way into the blood vessels.

Most of the exponents of intraprostatic injections have based the rationale of such treatment on the supposition that the chemicals injected have a direct bacteriocidal effect on the organism present in the prostatic acini. Grant says that he does not know how the mercurochrome does act, but believes that it exerts a local bacteriocidal and bacterostatic action, since it does remain in the gland for an extended period. It apparently does not act in the same obscure biological way as it does when injected intravenously. As pointed out elsewhere, the action is probably due entirely to the resulting fibrosis and contracture which occludes the infected acini.

The technique of injection used by Grant and usually employed by others is as follows: Gas is the anesthesia of choice as the procedure is by no means painless. First the bladder is filled with sterile water, in order to displace the prostate downward as far as possible. Both vasa are then exposed through a small incision in the upper part of the scrotum, and each vas injected with 10 cc. of freshly prepared solution of 1 per cent aqueous mercurochrome. Thus each seminal vesicle is distended with the antiseptic. The patient is then placed in the lithotomy position and with the left index finger in the rectum to act as a guide, an 8 inch 20 calibre needle is introduced into the lateral lobe of the prostate through the perineum. The needle is readily guided into the prostate by the rectal finger, and as it passes through the prostatic capsule increased resistance is felt. The needle is passed on for one-quarter to one-half inch into the gland. The hub of the needle is then connected to a 10 cc. Luer Locktite syringe, and moving the point of the needle about, 5-10 cc. of mercurochrome is injected into the lateral prostatic lobe. The needle is then withdrawn from the capsule and reinserted

into the opposite lobe and the injection repeated. Some pressure is required to force the fluid into the gland, so if it goes in too easily the needle is probably not in the prostate. Twenty cc. is the total amount usually injected. The prostate is then thoroughly massaged to disseminate the mercurochrome, and the bladder then emptied.

The urethral method of prostatic injection is accomplished through a specially constructed needle introduced through the McCarthy panendoscope under direct vision. The needle is inserted for one-half inch first into one lobe and then into the other. The syringe is attached to the needle and 5-10 cc. of mercurochrome injected into each lobe. This is the method of injection suggested by McCarthy. There is no great choice between the two methods, as both serve the same purpose satisfactorily.

Follow-up treatment consists of prostatic massage twice weekly, together with daily hot sitz baths for a few days. As a rule all pus disappears from the prostatic secretion three to five weeks postoperatively. The prostatic secretion is often tinged with mercurochrome as late as four weeks. As part of the follow-up treatment, attention must be directed to any other focus of infection that may be present, such as teeth, tonsils, sinuses or colon, in order to prevent a recurrence of prostatic infection.

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#### THE INSURED NEUROTIC

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The insured neurotic is a problem to tax the judgment of the insurance examiner after most careful observations. The motive to malingering is evident and the "wherewithal" to remain away from the intolerable situation or evade responsibility is present. The examiner wants to be fair to both the insured and the insurer. It takes time to convince the former of this desire. In fact, it takes several days of sympathetic conversation and conscientious diagnostic work to gain this point, as well as to secure data for a comprehensive report. The patient and his wife have reported to one to whom they feel antagonistic because that one was selected, not by them, but by a company apparently desirous of discharging a liability. If the examiner can forget that it is an insurance case while he is examining the patient and discuss the patient's disability as though the patient had come voluntarily for help, the examiner will radiate confidence that will be absorbed by the patient. Usually on the second visit and after the family has discussed the attitude of the examiner at the first visit, the wife will prefer to shop or wait in the reception room during the period her husband is with the examiner. During the previous visit, she had clung to him like a leech, lest the examiner might attempt to take unfair advantage of her disabled husband.

The insured doubts details of an examination and their motives. For example, when a sample of handwriting is desired, it is better to ask the patient to write some indefinite sentence than to sign his name. He fears a signature on a blank card may be subterfuge for signing a waiver of claim that might later be typed above his signature.

When the insured is a neurotic, the examiner may often serve beyond his sphere as an adjuster when the company's adjuster would be received skeptically, by recommending that the insured be permitted to resume his occupation or enter a new field of endeavor without loss of insurance security, between the amount of his occupational income and his compensation check, for a definite trial period.

Read before the Second Annual Meeting of Medical District D, Bradenton, September 29, 1938.



This gives the patient a chance to prove to himself that he may become rehabilitated without the impending fear of being cut loose in a cruel world without funds, by attempting a gainful occupation and by failing in it. Since the neurotic did not premeditate insurance compensation beyond that of normal security, he is not likely to have paid excessive premiums beyond his earning power; consequently, his private endeavor will soon exceed his compensation check which would automatically cease to come. For a person to hold policies well beyond his expected ability to pay premiums would suggest premeditation through malingering. Insurance companies are most cooperative and apparently appreciate instead of resenting such "meddling."

If it were not for the personal equation of the attending physician-patient relationship, a copy of the report would be helpful to the examiner for it would be additional scientific data which he could use to advantage in the treatment of the patient. Insurance companies primarily want their claimants to get well so that they become payers instead of payees. However, Dr. I. Read Stidger, Medical Supervisor of the Prudential Insurance Company of America, comments on this thought as follows: "From our view, this would be a dangerous practice as occasionally it puts into the hands of those who might take a dispute to court the material on which a defense of a claim could be made. One should realize that the relationship between the attending physician and the physicians selected by the insurance company for an independent opinion is not the same as that which exists between the attending physician and the specialist to whom the attending physician refers a patient. The opinion expressed by the specialist may not be at all in accord with what the attending physician thinks or may have told the insured and opportunity for disagreement and other forms of unpleasantness may thus be created. I do not mean to imply that we are prone to go to court; on the contrary, we studiously avoid such a procedure. No doubt, in certain instances, free transmission of findings to the attending physician is helpful. In deference to the legal angle connected with our work, it has always been the practice to expect that no such information be divulged without per-

mission of the Company in each instance."

Naturally psychoneurosis and malingering are easily confused especially where a financial motive does exist as in insurance examinations. Too often, physicians are prone to interchange their meanings in conversation. To accuse a neurotic person of malingering is grossly unfair, for he is actually sick and this error is undesirable to insuring companies. Yet to carry a malingerer on disability is to abuse a sacred trust conferred upon the physician by the insurer.

There is naturally a tendency of attending physicians to favor the insured, either because the physician knows and likes him or in rare instances, there exists an ulterior financial motive of being assured his fee from the insurance check. Companies call upon other physicians to secure less biased deductions and these consultants are usually men especially qualified in the field of practice in which the disability of the claimant falls. From these men, companies want facts for any case may be brought to court and no company wants its testimony to fall short because the special examiner felt inclined to favor his employer.

To frankly diagnose a case as malingering is rather harsh because it is an accusation of fraud. Should it go to court, the examiner would not have to defend himself as in a case of slander but the jury will tend to sympathize with the insured, whom it believes is being persecuted, and against the physician and the company he represents. However, since many policies require a total permanent disability rating to assure payment of claims handled by psychiatrists, an examiner may have the opinion that the case is either partial or temporary in nature. He may otherwise comment that he cannot find evidence to support the claimed symptoms. Companies usually tell examiners the type of policy held by the insured.

Malingering is more likely to exist where bulk settlement is expected as following an accident. In these types of cases, the malingerer often employs an attorney of shady reputation to present his claim. Knowledge of the attorney can be some guide to the physician. The malingerer, unlike the neurotic, gets tired acting disabled. His disability

is in his conscious mind. He does not want much conversation with the examiner and resents examination, because he is afraid of being trapped, or if he realizes this, he may overdo his act. Very occasionally, anxiety neurosis develops through the mechanism of fear and clouds the picture through its vegetative symptoms. Because the malingerer is not sick, he has time to rest from acting when unobserved. This saves his emotional reserve. Companies go to great expense to expose malingerers. Motion pictures have been made of their actions without their knowledge. These are most persuasive proof of fraud. On the other hand, companies are very tolerant of the neurotic claimant.

Dr. Wm. S. Sadler in his *Theory and Practice of Psychiatry* (Page 674) states that the malingerer or simulator of disease may be detected as follows:

1. The malingering onset is sudden. In the true neurosis and psychosis there is always a prodromal period of insomnia, malaise, irritability and restlessness.
2. Symptoms are exaggerated and overacted if long continued.
3. The malingerer's symptoms are inconsistent with any type of neurosis or psychosis.
4. Symptoms are produced to order—rapidly changed from day to day.
5. When the malingerer thinks he is unobserved, the symptoms are not maintained.
6. All constitutional signs of ill health are absent.
7. Very seldom does he refuse food.
8. Insomnia cannot be maintained.

Psychoneurosis is an involuntary retreat from an intolerable situation with the victim living in a world of reality and is a disorder of the unconscious mind. The neurotic fears getting well because his disability masks his inadequacy. He does get pleasure in telling his symptoms at length and having someone listen to him and sympathize with him. He will have more or less definite persistent symptoms whether he believes he is being observed or thinks he is alone. Psychoneurosis is hypostatized by fear. Fear normally prepares the animal for flight or if he is cornered, for fight, through stimulation of the suprarenal gland with an abundant pouring of adrenalin into his blood stream. It is on this mechanism that concrete laboratory differentiation can be based. Prolonged fear exhausts the suprarenal and through the vegetative nervous system other ductless glands attempt to compensate. These are hyperactive at first but later exhausted. Hormone content of blood becomes deficient.

Proving endocrine deficiency through laboratory work is a great help in differentiation. Laboratory findings in addition to the usual symptoms of differentiation banish much doubt. Since doubt on the part of the examiner keeps many on compensation, the additional cost is willingly paid by companies. One can be reasonably assured that the claimant with a normal endocrine balance is not desperately in need of financial help because of his disability. If he is a mild neurotic, putting him back to work will cure his neurosis. If he malingers, there has been one more victory for scientific medicine.

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## DIAGNOSIS AND TREATMENT OF STERILITY

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From ancient times the reproach for barrenness has been visited upon the wife, and the cause has been assumed to be some abnormality of her reproductive organs. Consequently the problem of sterility is assigned by tradition to the gynecologist. In the last few years there has been much progress in this field, flooding the literature with a myriad of articles, so that this discussion must of necessity be only in skeleton form. Not only have we found that the husbands must share much of the responsibility for infertility, but also that the depressed constitutional states are causative factors almost as important as are local genital disorders. Meaker<sup>1</sup> has long ceased to speak of sterility in man or woman; a more accurate concept in his opinion is that of the sterile mating. The complete investigation and treatment of sterility must, therefore, involve work in several nongynecologic fields of practice, particularly in urology, internal medicine, and endocrinology. Each couple presents a research problem within themselves.

Many confusing terms have been proposed, but we may divide all cases into three general classes: absolute sterility, in which there is absolutely no possible chance of the person producing active gametes or having their gametes accessible to the gamete of the opposite sex; relative sterility, in which a person

<sup>1</sup>Read before the Hillsborough County Medical Society, May 3, 1938.



is sterile at the present time; and low fertility, in which a patient is not sterile, but offers so many impediments to the gamete of the opposite sex that fertility, at least in this mating, is improbable. We may further divide these patients into those having primary (congenital) or secondary (acquired) sterility, the former being due to anatomical deficiency, the latter resulting from some intervening pathological condition.

#### ETIOLOGY

1 Deficient spermatogenesis may be due to a congenital absence or pathological destruction of the sex glands, failure of development because of lack of endocrine stimulation, or to exocrine causes such as sexual excesses, or depressed constitutional states resulting from chronic intoxications or constitutional diseases.

2 Obstruction and occlusion in the male genital tract most commonly results from epididymitis accompanying gonorrhea or tuberculous infection, or may result from stenosis of the urethra or ejaculatory ducts following inflammation or operation.

3 The prostatovesicular secretions may be hostile to the sperm either because of chemical or bacterial properties, or because of physical constituency,—viscosity.

4 Faulty delivery and reception of the sperm may be due to anatomical defects of either sex or to incomplete coitus resulting from impotence in the male or dyspareunia in the female.

5 Hostility of the vaginal and endocervical secretions may be chemical as evidenced by acid vaginal secretions which kill the sperm,<sup>2</sup> or by failure of the semen to have a sufficient quantity of lytic substances with which to dissolve the mucus plug of the cervix. It may be bacterial with a viscous, purulent discharge filled with leukocytes and bacteria impeding the progress of the sperm either by physical or chemical action. Or it may be serological, as Baskin<sup>3</sup> and Escuder<sup>4</sup> have demonstrated that the cervical secretions in women who had been injected intramuscularly with semen, were hostile to spermatozoa, as was the serum from such women when mixed with specimens of fresh semen in hanging drop preparations.

6 Uterine or tubal obstruction or occlusion may be primarily developmental or, secondarily, the result of inflammation, pressure

by tumors or adhesions, or the result of endocrine over-activity.

7 Impassability of the ovarian hiatus may result from abnormal location of the ovary, adhesions, or abnormal peritoneal folds.

8 Deficient oogenesis may be endocrine or exocrine as mentioned for deficient spermatogenesis, or may result from inflammation, tumors, congestion, and roentgen rays.

#### DIAGNOSIS

In the past the clinical investigation of a case of sterility started with examination of the female pelvic organs and progressed only to the point where the first real or fancied cause was identified. The normality of all other items was then taken for granted, investigation ceased, and treatment began. The essential feature of a modern examination is always completeness, in the sense that every etiologic possibility is routinely surveyed. Every sterility problem requires study from four viewpoints,—that of the urologist, gynecologist, internist, and endocrinologist.

The urological examination must start with a full history, giving especial reference to the following points: potency by former marriages or marital relations; the existence of venereal disease with or without epididymitis and the extent of residual damage as evidenced by difficulty in voiding and occasional discharge; previous injury to the testicles or complication of orchitis following mumps; and, finally, details of the sex life with reference to the use of contraception, method of coitus, frequency of coitus, libido, potency, etc. The examiner should look for hypoplasia, atrophy, congestion, or failure of descent of the testicles, thickening of the epididymis from old inflammation and varicoceles, and anatomical deficiencies such as hypospadias or epistadias. Prostatovesicular inflammation or congestion may be ruled out by rectal examination and microscopic study of the smear taken from the secretion expressed following the prostatic massage. Failure to obtain such secretion would point to obstruction of the vesicles while the presence of pus, bacteria, or abnormal mucus would point to a chronic inflammation. Lesions of the posterior urethra may be found only by the passage of a sound or endoscopic examination which will show congestion of the verumontanum, strictures, etc.

Finally, and probably of most importance, is the examination of a condom specimen, obtained in a clean condom (free from powder, etc.) and kept warm while in transit to the office by enclosing it in an envelope and carrying it in an inside vest or shirt pocket. The semen would have a hydrogen-ion determination as the normal range is from pH 8.0 to 8.4. The volume should be between three and six cubic centimeters, and the texture should be smooth because the normal mucolytic action should have reduced all mucus plugs to an even consistency. The sperm should be motile when examined by hanging drop preparations. By count there should be between seventy-five and two hundred million sperm to a cubic centimeter, and upon examination of a stained smear there should be less than 19 per cent of abnormal forms.<sup>5</sup> The detailed semen examination has done away with the totally erroneous conception that fertilizing power and motility of the spermatozoa are synonymous.<sup>6</sup> Fertilizing power is undoubtedly lost long before motility ceases and sperms which never were normal and evidently are totally incapable of fertilizing an ovum may be actively motile. We now know that the seminal vesicles are not the reservoirs for the spermatozoa but the graveyard and that the sperms produced in the tests and endowed with some motility move on to the tail of the epididymis where they are stored and kept immobile by the lack of oxygen and inhibiting secretions of that region. Moench<sup>7</sup> has found that practically every man who had deficient spermatozoa had a low basal metabolic rate.

The history from the gynecologic standpoint must include evidence of fertility by former marriages, a history of venereal disease, "ovary trouble," appendicitis, or "inflammation of the bowels," together with leukorrhea, dysuria, or other symptoms referable to a pelvic inflammatory process. Pelvic or abdominal operations must be carefully investigated. The menstrual behavior, with reference to the age of onset, character of the early menses, present type, amount, duration, rhythm, and presence of pain, is of importance while a sex history must be taken from the woman as her reaction may not always be the same as the husband, and a mild degree of dyspareunia may be present.

A thorough abdomino-pelvic examination will elicit the presence of anatomical variations such as double cervix or vagina, bicornuate or abnormally shaped uterus. The presence of a chronic skenitis or Bartholinitis will point to a previous nicherian infection, and a chronic inflammation of the cervix with a possible stenosis resulting from trauma or infections may show an impediment to the advance of the sperm. Rucker<sup>8</sup> found that 36 per cent of the patients with primary sterility and 65 per cent of those with secondary sterility became pregnant when treated for cervicitis. Lesions of the urethra, vulva, vagina or pelvis producing tenderness will result in a dyspareunia. A chronic pelvic inflammatory condition of the broad ligament, tubes, or ovaries will obstruct by adhesions or agglutination of the mucosa, and the resulting fixed retroposition with its chronic congestion may be responsible for habitual abortions. A movable retroposition, however, has been found to be present in 14.2 per cent of normal pregnant women examined within the first three months of gestation, while abortion was found to be no more common in the retroverted than in the anteverted movable uterus.<sup>9</sup>

The endocervical secretions should be studied by making a smear to determine the presence of bacteria, pus cells, and mucus, and the hydrogen ion determination should show a pH of 8.0 to 9.0. An estimation of uterine development by determining the relation of the length of the cervix to the length of the fundus, gives additional data of the endocrine stimulation for the infantile cervix is twice as long as the fundus. The retroposition, with the resulting abnormal position of the cervix, is a part of the picture of pseudo-infantilism rather than actual hinderance to fertility. Green-Armytage<sup>10</sup> states that genital hypoplasias are responsible for 44 per cent of the cases of primary sterility in women.

The test for tubal patency is of great significance, and may be made either by the "tubal insufflation" technique or by the injection of lipiodol and roentgenological examination. The latter is held by some to be superior to internal pelvic examinations. Finally, one of the most important examinations is the Huhner test.<sup>11</sup> The woman is examined as soon as possible after coitus and the



contents of the seminal pool in the posterior vaginal fornix, together with the contents of the cervix, are aspirated with a small pipette and studied by the hanging drop technique to determine the location of the sperm and their degree of motility. By this means chemical and serological substances will have had a chance to act by inhibiting the motility of the sperm or causing their destruction.

The internist must take especial pains to rule out foci of infection, and to find evidence of syphilis (Wassermann examination) and other constitutional diseases such as malaria and tuberculosis. Digestive disturbances, together with biliary toxemias and constipation, produce anemia and malnutrition. The personal hygiene must include a proper proportion of exercise, rest and fresh air, while the diet necessarily must contain sufficient amounts of the essential minerals and vitamins, i. e., manganese and B<sub>2</sub>.

The endocrinological investigation presumes that the history will elicit changes in the weight of the patient, the presence of skin diseases, the growth or loss and the distribution of hair, the presence of headaches, vertigo, nervousness, fatigability, psychosis, or palpitation and dyspnea. The menstrual history is of great assistance in estimating the amount of endocrine disturbance. Biometric determinations of endocrine substances are now being used in locating the deficiency. The physical examination will give especial attention to the skeletal growth and structure of the hands and face. Enlargement of the thyroid gland is looked for while vasomotor disturbances, tremors, and the presence of exophthalmos fill out the picture. Changes in the temperature, pulse and respiration rate, blood pressure, carbon dioxide content of alveolar air, and lung volume give evidence of disturbances in metabolism resulting from an imbalance of the endocrines. Additional tests such as the determination of the basal metabolic rate, sugar tolerance test, cholesterol determination, nitrogen partition test and a complete blood study are needed to make the examination complete.<sup>13</sup>

Because of the dependent interrelation of the endocrines, we find evidences of disturbed growth or physiology of the genital tract in many diseases which are primarily dependent

upon the function of one gland. In disturbances of the thyroid gland, a hypothyreosis will cause cretinism, dwarfism or myxedema, while in hyperthyreosis such as Basedow's disease, we have a "constitutional pluriglandular affection," with a combination of dysmenorrhea, metrorrhagia, or anemorrhoea, and the sterility will depend in a large part upon the extent of secondary ovarian pathology. In pituitary disturbances there frequently is an extensive degeneration of the follicular apparatus in the ovaries. Pseudo-infantilism is found in hyperfunction as in pituitary giants, and in hypofunction as in pituitary dwarfs. Atrophy of the anterior lobe may be due to tumors, emboli, and inflammatory processes, an example of which we find in Simmon's disease which is characterized by an atrophy of this anterior lobe in adult life with a resulting decrease in libido, amenorrhea and sterility. Dystrophia adiposo-genitalis or Frohlick's disease, is another example of pituitary disturbance. When there is a hypofunction of the adrenals as in Addison's disease, we find amenorrhoea, atrophy of the ovary and sterility resulting, while an overactivity results in precocious sexual development, masculine traits and frequent sterility. A persistent thymus has been supposed by some to cause genital infantilism, but may be only a symptom of some other glandular dyscrasia.

The last step in the complete diagnostic study of a sterility problem is the correlation and evaluation of the data obtained by the several investigators. At almost every stage in the analysis of a case it is found that independent studies are interrelated and complementary. The final result is the reduction of each problem of causation to its simplest terms,—a definite number of demonstrated factors. Thus the way of treatment is clearly indicated.

#### TREATMENT

The ideal treatment of sterility would remove all impediments and so bring about a condition of perfect or absolute fertility. The practical aim of treatment, therefore, is to remove at least a sufficient part of the depressing sum total of causes, so that the fertility may be increased. From the viewpoint of the parents, the ability to have a baby is more im-

portant than any abstract question of physiologic perfection. Many cases are often remedied by the simplest treatment; indeed, a spontaneous cure is not uncommon. However, more elaborate therapeutic measures are often necessary, while in some instances all treatment is unavailing. In an ordinary case of relative sterility where four or five causative factors are present, the removal of any two or three may be sufficient to permit conception, even though the others are not treated. Thus, it is understandable that a given sterility might be successfully treated by a half dozen different therapeutic programs.

1 Deficient spermatogenesis. In the male, local conditions such as undescended testicle, etc., may be treated with operation augmented by endocrine therapy.<sup>14</sup> Chronic passive congestion when associated with varicocele may be treated by suspensory or operation, and deficient spermatogenesis might be treated by roentgen rays. If, as Moench has suggested, deficient spermatogenesis is correlated with a low basal metabolic rate, then thyroid extract and pituitary extracts should be administered. However, in endocrinologic treatment it must be admitted that up to the present time the results have not been satisfactory, probably due in the most part to the neglect of four fundamental principles: the patient must exhibit a genuine endocrine deficiency; non-endocrine causes must be corrected; the primary focus of endocrine failure must be identified and treated; and the necessary endocrine medication must be given in potent form, in adequate dosage, and for a sufficient time. The correction of systemic debility by the elimination of foci of infection, abolition of mechanical or drug intoxications, and the treatment of general constitutional conditions such as syphilis, anemia, etc., is important.

2 Deficient oogenesis. Endocrine deficiencies and intoxications as mentioned above influence oogenesis also. Menstruation may well occur without ovulation if we accept the work of Hartman<sup>15</sup> upon the primates. Ovulation has been produced in women by using the blood serum from pregnant mares or the gonadotropic substance from such serum.<sup>16</sup> Pregnancy has occurred and ovulation demonstrated by examination of the ovaries at the time of operation. The formation and extrusion of

ova is further assisted by administration of pituitary extracts with corollary stimulation of thyroxin or desiccated thyroid substance.<sup>17, 18</sup> There is no theoretical justification for the use of esterlin or progestin in cases in which there may be a deficiency in ovulation.<sup>19</sup> A deficiency of the vitamins or mineral constituents of the diet must be corrected.

3 Obstruction and occlusion in the male genital tract. Urethral strictures call for dilatation or urethrotomy, while a complete epididymal blockade may be treated by epididymo-vasotomy, or artificial insemination of the cervix with material obtained by puncture and aspiration of the testicle, neither of which holds much promise.

4 Hostility of prostatovesicular secretions may be treated by topical applications of the posterior urethra or massage of the prostate and vesicles in an attempt to clear up the causative chronic inflammatory condition.

5 Faults of delivery and reception. In the male, lesions of the verumontanum, such as congestion, hypertrophy, ulcers, or polypi, must be treated. Hypospadias and epispadias are in some instances amenable to operative procedures, and insemination of the cervix has been accomplished by the use of a condom which has a small perforation at its tip, thus allowing the semen to enter the vagina. Expert psychologic management and treatment of the nervous system is important. Anatomic maladjustments and disproportion, allowing intercourse but preventing cervical insemination, may often be overcome by instruction in the technique of coitus adapted to the particular nature of each individual. In the female malformations and deformities preventing the entrance of the penis may be remediable by surgery. Ulcers or inflammations of the introitus or vagina must be treated and stenoses or contractures of the canal may be dilated or corrected by plastic surgery. Vaginismus which is not due to the above cause is to be treated by psychiatry.

6 Hostility of vaginal and endocervical secretions. Vaginitis from *Trichomonas* or monilia infections causes sufficient leukorrhea and changes in the vaginal secretions to impede the motility of the sperm.<sup>20</sup> The treatment is fairly specific for each of these, certain arsenical preparations or picric acid being used for the former and genital violet appli-



cations for the latter. The first requisite in the treatment of viscosity of the endocervical mucus is free drainage, which is provided for by a posterior median discission. When adequate drainage is established, further treatment is directed toward the cure of chronic passive congestion and infection by cauterization, coagulation, glycerine tamponage, and hot douches. Dilatation of the canal and uterine sounding are only transient in their effect.<sup>21</sup> Curettage causes a temporary stimulation of the endometrium and with its associated dilatation can sometimes allow pregnancy. The optimum time for dilatation is about ten days after the start of the last menstrual period.<sup>22</sup> Removal of cysts and occasionally operative repair of the cervix will be found necessary. Sexual abstinence, which allows the decrease of pelvic congestion as well as the disappearance of spermal antibodies, is of great importance, thus changing the physical and chemical nature of the cervical secretions. Dissolution of the mucus plug by alkaline solutions has been tried with but little success.

7 Uterine blockade. Aside from cervical stricture, faulty development, tumors,<sup>23</sup> or acute flexion may necessitate surgical intervention. Endocrine irregularities which cause a scant or overabundant mucosal development may also interfere with implantation of the ovum. Novak<sup>24</sup> believes that hyperplastic endometrium, being probably due to a lack of progesterin, not only is an improper endometrium for reception of the impregnated ovum, but is void of the hormone so necessary for assisting in proper nidation. Moench<sup>7</sup> comes forward with the idea that premature labors and abortions are due to excessive amounts of esterine as he believes that fibroid tumors in the uterus are due to this same excessive hormone production. Both views would lead one to try the administration of progesterone<sup>25</sup> for a beneficial effect upon the implantation and continuation of pregnancy. Adherent retropositions because of their tendency to passive congestion tend frequently to favor imperfect implantation or nidation. However, it has been found that a movable uterus in retroposition is not responsible for sterility, but is usually only another stigmata of an underdevelopment or pseudo-infantilism due to endocrine causes.

8 Tubal and peritoneal obstruction to the migration of the ovum. The initial step in the treatment of tubal blockade is the elimination of chronic passive congestion and of any active inflammation by the usual palliative measures. The diagnostic tubal insufflation may have been sufficient to have broken down small adhesions and admit the ovum; however, it may be advisable to repeat the procedure several times, supplementing it with the injection of iodized oil.<sup>26</sup> Conservative pelvic surgery seeking to break up adhesions, remove tumors, or restore the patency of the fimbriated end of the tube, is often successful and an infected tube should always be removed to alleviate the focus of infection within the pelvis, permitting subsidence of the inflammation if it will not respond to conservative treatment. Beclere<sup>28</sup> presents roentgenological data to show that conservative treatment of the pelvic inflammatory conditions by diathermy favors the restoration of tubal patency. Meaker<sup>1</sup> believes that properly performed salpingostomy is a valuable procedure. However Greenhill,<sup>27</sup> in an analysis of 818 plastic operations collected from many surgeons by questionnaires, found only 54 pregnancies to have occurred, an incidence of 6.6 per cent or one pregnancy for every fifteen operations. Of the 54 pregnancies that occurred, only 36 live babies were delivered and there were eight ectopic pregnancies.

Abnormal folds in the peritoneum, together with adhesions, are to be sought and eliminated as possible impediments to the progress of the ovum, while the suspension of a prolapsed ovary is frequently quite sufficient to cause a normal migration. Mechanical impediments of maturation and rupture of the graafian follicles can be remedied by conservative ovarian surgery which comprises several procedures: partial resection, decortication, puncture of follicular cysts, and excision of persistent corpora lutea.

9 Artificial insemination. When by every test the female has been found to be normal and fertile, and the male infertile, then artificial insemination may be tried. There are many legal aspects of this situation<sup>28</sup> and the results are reported with varying degrees of success by different men.<sup>29, 30</sup> If artificial insemination is to be tried one must remember

that pregnancy often may not result from one individual act of coitus; hence it must be repeated many times.

#### CONCLUSIONS

Dr. Samuel R. Meaker, Professor of Gynecology, Boston University School of Medicine, and author of the chapter on *Sterility* in the *Treatise on Gynecology and Obstetrics* edited by Carl Henry Davis,<sup>31</sup> to whom I have liberally referred in this paper, states that prevention of sterility is the duty of every physician. The responsibility of recognizing early endocrine disorders in young people, the prevention and rational treatment of genitourinary disorders in both sexes, together with the correction of sex hygiene, falls upon each of us. "Faults of sex hygiene occur with distressing frequency in modern marriages. While female orgasm is not of course necessary for conception, habitual excitation without relief leads to chronic pelvic congestion; and this in turn produces local abnormalities, particularly disturbances of the endocervical secretions and low-grade degenerative changes in the ovaries. The need is apparent for an educational program to combat errors in this department of hygiene, not only because of their adverse effect on fertility, but also because of their large contributions to the unhappiness of individuals and to the ills of society."<sup>31</sup>

Unnecessary and maladroit treatment should be discouraged. Badly done plastic operations on the cervix or radical curettages of the endometrium may cause the very condition which they were intended to cure. The fertility of a nation is favored by such economic adjustments as make early marriage possible, since waning of the reproductive capacity begins naturally during the fourth decade of life. For this reason childless couples should be taught to seek competent help without undue delay, preferably after no more than one year of involuntary barrenness. Any well-rounded program for the management of human fertility must obviously extend beyond the medical field, since the preventive aspect involved projects into economics, into sociology, and into education.

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## FOREIGN BODIES OF THE CORNEA, THEIR REMOVAL AND SUBSE- QUENT TREATMENT

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Of all the different procedures in minor surgery of the eye, the most important is the removal of foreign bodies from the cornea. This importance is due to several factors; the location, i. e., the foreign body may be in the pupillary area; the likelihood of penetration, and the always present danger of subsequent infection. Small to large amounts of vision are lost as the result of improper handling of seemingly trivial cases. It will be my purpose to describe a simple and effective, although not original, method for management of these cases.

Diagnosis is extremely important especially as to the position of the foreign body and its depth in the cornea. The upper lid should be everted in all cases, even though a foreign body is seen on the cornea, and the upper cul-de-sac inspected. Fluorescein, 1 per cent solution, should be relied upon in those cases where no foreign body is visible with a loupe and focal light, as a faint stain will often show a foreign body which would otherwise be overlooked. Moreover, pinpoint ulcers and fine foreign bodies are often seen only at one tangent and not straight ahead. Therefore, examining the eye from different angles is very important. The differential diagnosis should include the brown pigment spots on the iris which are often taken for foreign bodies deep in the cornea, and the presence of previous small nebulae. Where no foreign body is present, staining with fluorescein may show the superficial laceration left from trauma. The depth of penetration can be determined at this time either by observation at a tangent, or with the ophthalmoscope or slit lamp.

The first essential in removing a foreign body is thorough anesthesia of the cornea. A local anesthetic should always be used, and I prefer pontocaine,  $\frac{1}{2}$  per cent solution, as it causes very slight discomfort. A drop of adrenalin can be used if much congestion is

present but usually it is not necessary. The eye is then irrigated with 1-5000 solution of oxycyanide of mercury.

Another important factor is proper illumination, which may be procured either by the use of a head lamp or with a head mirror. Proper magnification is also essential, and of great importance is the type of instruments used in removal. In my experience a cataract knife and dental bur have proved of most value and have produced the least amount of trauma.

The older magnifying loupe, such as the Berger or Beebee, is cumbersome. I should like to describe to you the loupe which I am using and which was originated by Dr. Nelson M. Black of Miami. This loupe is very ingenious in that it is compact and can be carried in an ordinary spectacle case. The loupe consists of a pair of carrier lenses, to each of which is cemented a  $5^\circ$  prism, Base In, with a plus 4.00 spherical power. The spherical power determines the range or working distance—the stronger the power, the shorter the range. It is advisable when the operator requires a correction, especially for near work, that this correction be added to the carrier lenses. These lenses may be mounted in any desirable spectacle frame.

After the proper anesthesia of the cornea and the location of the foreign body, it should be removed with the least possible trauma, using either the cataract knife or Berger spud. When the foreign body is deep a sharp spud should be used to undermine the edges so that the removal will be easy. With deeply penetrated foreign bodies great care should be exercised so that the offending material is not pushed deeper into the cornea. The wound is then examined for rust and if any is present it is removed by the use of a dental bur, size  $\frac{1}{2}$ . This bur is held between the index finger and thumb of the right hand, placed on the site formerly occupied by the foreign body and then rotated. The eye is re-examined and if any rust particles still remain, the bur is re-inserted and the same procedure carried out. Of course, the bur must be rotated with the most delicate touch. The wound is then cauterized with either tincture of iodine or phenol, using a round toothpick which has been dipped into one of these solu-

tions. I prefer phenol because of its anesthetic value.

If the wound is clean and there are no inflammatory symptoms present, butyn ophthalmic ointment, 2 per cent is applied to the lower conjunctival sac and gently massaged over the eyeballs. Bandaging an eye after this treatment is absolutely contraindicated, as drainage of tears with the washing away of secretion is prevented, and virulent bacteria are walled up so that a perfect culture medium is made; only a loose eye shield or dark glasses to lessen glare is indicated.

A tube of butyn ointment is given to the patient, and he is advised to use it every two or three hours until the following morning, or as long as he is in pain. He is instructed to report at the office the following day if he has any pain or discomfort. If there are inflammatory symptoms, which sometimes are caused by delayed removal, and the tension of the eye is normal, two drops of a 2 per cent solution of homatropine are instilled into the eye, and the patient is advised to use hot compresses at home, returning the following morning for further treatment. When he returns, if the inflammatory symptoms are still present, two drops of a 1 per cent solution of atropine are instilled into the eye, and the patient is instructed to report daily for treatment until recovery is complete.

Before discharging the patient as cured, his visual acuity should be taken, as frequently these patients go to court claiming loss of vision. A record made at this time will offer convincing proof in court.

With the procedure outlined the majority of patients recover and are able to return to work immediately. Rarely do the inflammatory processes extend with the production of corneal ulcer, iritis, and a possibility of panophthalmitis. The scope of this paper does not permit discussion of complications following the removal of a foreign body.

The technique outlined has been of such assistance to me that I hope it will be of some value to you.

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## MAXILLARY SINUSITIS ASSOCIATED WITH DENTAL CARIES

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In presenting this subject of maxillary sinusitis associated with dental caries, I hope to make all of you realize the importance of this type of infection, particularly as a focus of infection.

After a brief description of the anatomy of the maxillary sinus I will limit my discussion to maxillary sinusitis of dental origin. Various rhinologists have presented statistics to prove that from thirty to fifty per cent of all antral disease is of dental origin. Dunning, (D.D.S.),<sup>1</sup> believes that fifty per cent of maxillary disease is oral in origin. These figures do not seem too high in my experience. In recent years there has been an increased interest in, and recognition of, pathology of the antrum by dentists and exodontists. This has brought to light many latent chronic cases of maxillary sinusitis.

Due to the high floor of the maxillary sinus in children, infections of this sinus from dental caries are rare or do not occur. I have never seen an infection of the maxillary sinus due to dental caries in a patient of less than 18 years of age, and have not been able to find any cases reported in literature. For all practical purposes, the maxillary sinus has reached its maximum growth at fifteen years. The maxillary sinus when fully developed is the largest of all the paranasal sinuses.<sup>2</sup> Since it is formed by absorption of the cancellous structure of the body of the maxilla it follows generally that the larger the sinus in a given case, the thinner the walls; however, the size is influenced by many environmental conditions. Old age influences the thickness of the wall. The maxillary sinus is pyramid shaped. The upper wall, or roof, forms the floor of the orbit. The floor of the sinus which we are considering lies above the alveolar process and hence is in more or less close relationship to the teeth. Should you look into the maxillary sinus from above, in a large number of instances you will see mounds of bone rising from the floor into the cavity to

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various heights, causing the surface to look quite bumpy. The bumps mark the sites of the roots of the teeth. Should you chip away the osseous covering of the tooth roots, you will find in some specimens that the bone is quite thick, sometimes quite thin, while occasionally there is no osseous covering whatsoever, the fangs being protected only by mucous membrane. Teeth having the closest relationship to the maxillary sinus are the molar teeth, but occasionally the pneumatization of the bone is carried forward to the median line over the incisor teeth.

In this paper we will not consider the infections of the maxillary sinus due to faulty technique in extracting teeth. Fortunately these cases have been few in my experience. The infections of the maxillary sinus found at the time of extraction are the material from which I am presenting this paper. Whether the sinus has become infected from the tooth, or whether the infected sinus has caused the floor of the sinus to become diseased is of question to me. Anatomically it seems quite possible that an infection of the maxillary sinus may cause destruction of the bony floor of the sinus which in turn destroys the lamina dura of the root of the tooth. Where an opening is made into the maxillary sinus during an extraction of a tooth the tooth socket should be closed. The sinus should be irrigated through the normal ostium or through an opening made below the inferior turbinate. The sinus should never be irrigated through the oral opening. Gerrie<sup>3</sup> states: "Removal of upper teeth is often impossible without severe damage to the antral floor, but the day of maxillary drainage through the alveolar process has long since passed." This should be avoided due to the bacteria that normally inhabits the oral cavity. Alexander,<sup>4</sup> in a series of several hundred cases, reports the organisms commonly found in the sinus and in their order of frequency: *Staphylococcus albus*, *Streptococcus haemolyticus*, *Streptococcus viridans*, *pneumococcus*, *Friedlander's bacillus*. Surely, if an attempt is made to irrigate the sinus through the tooth socket infection is bound to be carried from the mouth into the sinus.

In irrigating the sinus through the nares, either normal saline or potassium permanga-

nate solution 1-4000 may be used. A great many rhinologists use mercurochrome 1 per cent, osmosol, boric acid solution and other non-irritating solutions with equally good results. The kind of solution is not as important as the mechanical cleansing of the sinus. If one is fortunate enough to procure a clean sinus by repeated lavages, much has been done to give relief, at least, for the time being. Before dismissing the patient as cured one should make a roentgenogram of the sinus, inject a radio opaque substance into the sinus, and make another roentgenogram. This will show the condition of the floor of the sinus and will often reveal a cyst in the floor of what was thought to be a healthy sinus. Stevenson,<sup>5</sup> in summarizing 192 cases of chronic maxillary sinusitis which he operated upon states that: "Focal disease seems to follow this type of infection. Injudicious curettment of the sockets of the teeth opening into the maxillary sinus is to be condemned."

Many of these patients return years later, suffering with neuritis, arthritis, or some disease undoubtedly due to a focus of infection. They seldom complain of pain over the sinus. Diagnosis is made from the history of a tooth extraction many years before which opened into the maxillary sinus, and by careful roentgenographic study. Probably the weakest point in diagnosis of these cases is the lack of skill both the dentist and rhinologist show in making and interpreting roentgenograms.

During the past three years I have had five patients in which a portion of the tooth slipped into the maxillary sinus during an extraction. In these cases I did a Caldwell-Luc operation and found a diseased condition of the floor of the sinus. It is my belief that any sinus that is opened by the extraction of a tooth remains a source of infection even though lavage from the sinus may be clean. A roentgenogram made with radio-opaque material in the sinus has never given me the picture of a normal floor. I feel that only a thorough Caldwell-Luc operation will give these patients permanent protection. There is one objection to this radical operation, and that is the possibility of injuring the remaining molar teeth. Until two years ago I removed the tooth, or portion of the tooth, by making a window under the inferior turbinate, and as soon as the

lavage from the sinus was clean on three washings I inspected the sinus with Holmes' nasopharyngoscope. If the membrane appeared normal, I dismissed the patient. I have had many of these patients return after their physician could find no source of infection, suffering with arthritis or some disease due to a focus of infection.

During the past four years I have seen twelve cases of chronic maxillary sinusitis in which teeth had been extracted from two to fifteen years previously, and in which the teeth had left an opening into the antrum at the time of extraction. The opening had closed after various types of lavage, but radiographic study showed these patients to be suffering with a polypoid degeneration of the membrane of the maxillary sinus. Four of these patients are in the sixth decade of life and, due to their ages and associated diseases, I have lavaged the sinus in preference to doing a radical operation. One patient of this group has a coronary thrombosis and neuritis. The lavaging of the sinus gives this patient temporary relief from his pain. I irrigated his antrum ten times at two-day intervals, three years ago, and the neuritis apparently subsided. He returned to me one month ago suffering with the neuritis and, after the first lavage of his sinus, his pain became less severe. The other three patients have some degree of arthritis and lavaging the sinus from six to ten times has given them some temporary relief from their painful joints; but only a complete removal of the diseased membrane of the sinus will give them permanent relief. As already stated, I have not operated upon these patients due to their age.

I wish to summarize five cases in which the sinus was entered in extracting molar teeth. In these cases operation was performed and I found a degeneration of the floor of the sinus in the area where the teeth were removed.

CASE 1. Mrs. S. A. S., aged 32, consulted me August 21, 1936. Twenty-four hours before I saw her a root of the first right molar slipped into the sinus. A Caldwell-Luc operation was performed the day the patient consulted me. The mucous membrane in the floor of the sinus was very thick with a small polyp. The bone over an area the size of a dime surrounding the tooth socket showed roughness. This cancellous bone was curetted away as well as all the membrane of the sinus. The gum was sutured. This patient made an uneventful recovery. I saw her June 28, 1938, and she has had no trouble of any nature.

CASE 2. Mrs. A. G., aged 35, consulted me June 11, 1935, saying a piece of tooth had slipped into the left antrum that morning. A Caldwell-Luc operation was advised but the patient wanted the tooth removed through the nose. This was done, but continuous lavages failed to get a clean sinus, and the tooth socket remained open. The patient consulted another physician who attempted to burn out the tooth socket. This only enlarged the opening. Three months after the first visit to me I did a Caldwell-Luc operation and found an area the size of a quarter in which the bony floor was necrotic. I removed all membrane and diseased bone and, after a slow convalescence, the patient was cured. Two years later the patient returned to me with a low-grade temperature. She had a definite ethmoiditis with some pus from the left antrum. Two months ago a submucous resection, ethmoidal exenteration and an exploratory operation of the left antrum were performed. The membrane of the left antrum appeared normal, but there was a mass the size of a small marble lying upon the membrane in the floor. This mass was removed, and the pathological report stated: "The mass was a homogeneous deposit and possibly an accumulation." Three days following the operation the temperature subsided.

CASE 3. Mrs. J. C. consulted me August 19, 1936, stating that two years previously all upper teeth were extracted and since then she had had a foul discharge into her mouth. During the past year she had a stiffness of her fingers which her doctor diagnosed as arthritis. A radical operation was performed and the fistulous tract which was covered by membrane was curetted and all membrane of the sinus removed. The patient made an uneventful recovery as the socket remained closed and in two months following operation the stiffness of her fingers subsided. I saw this patient on the street about a month ago and she said she had had no ache or pain since she saw me professionally.

CASE 4. Mrs. S. R., aged 36, consulted me June 10, 1937, complaining of pain over the left cheek which had been intermittent for a year. One year previously an upper left molar was extracted and some pus drained from the antrum through the socket. A roentgenogram taken at this time revealed a polyp in the floor of the left antrum. June 19, 1937, I did a Caldwell-Luc operation on this sinus and found two polyps in the floor of the sinus. The patient made an uneventful recovery and has had no further pain over the sinus.

CASE 5. Mr. J. K., aged 27, consulted me July 21, 1936, at the request of his physician. He was having severe pain in the knees and hands. His physician had thoroughly checked him and could find no focus of infection. In a routine examination the left antrum appeared dark on transillumination. A roentgenogram at this time showed a polypoid degeneration of the mucous membrane in the floor of the sinus. After talking to the patient for some time he recalled that two years before this an upper second molar tooth was extracted and the dentist told him the root went into his sinus. He did not recall having any treatment for this except that the dentist packed the tooth socket. I operated upon this man, doing a radical operation, and four days after the operation he began having severe pain in the third upper molar on the operated side. This pain was very severe and, after consultation with a competent dentist, it was decided to extract this tooth. The tooth was extracted and the patient made an uneventful recovery. Six months ago I heard from the patient and he is now employed by a railroad and says he has had no further trouble with his joints.

In the three last cases the foci of infection proved to be the sinus. Had these patients been thoroughly studied at the time the teeth were extracted, much suffering could have been avoided.



Before closing, let me first stress the importance of a thorough check of any sinus that has been opened at the time of an extraction. This checkup should include a thorough roentgenographic study of the sinus. To accomplish this, the dentist and the rhinologist must take, or require his radiologist to take, more complete roentgenograms. In order to do this the rhinologist must be able to interpret roentgenograms. Second, I believe that most, if not all, teeth that make an opening into the maxillary sinus at the time of extraction do permanent damage to the sinus. This can best be corrected by removing the diseased membrane and bone in the floor of the sinus, which requires a radical operation upon the sinus.

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## PRONTOSIL IN THE TREATMENT OF MALARIA

### Case Report

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Hill and Goodwin, in the Southern Medical Journal, December, 1937, reported on the use of prontosil in the treatment of benign tertian and estivo-autumnal malaria. Intramuscular injections of prontosil were recommended at twelve-hour intervals. The amount of prontosil given intramuscularly was 10 cc.; the number of doses to effect recovery were four. One hundred cases were treated with recovery in all, no relapses, but with two reinfections which occurred one month after treatment.

A rapid recovery, such as this, would be a great advance in the management of malaria, especially in those patients severely nauseated and vomiting, and in those sensitive to quinine. Also patients who are reluctant to take atabrin because of discoloration of the skin or because of gastric irritation, could be satisfactorily treated by a regimen such as outlined by Hill and Goodwin.

#### CASE REPORT

J. T. V., a 50 year old white man has had an attack of malaria each spring for the last two years. Both quinine and atabrin caused severe nausea and vomiting in the last two attacks. Malaria in the spring of 1937 was treated with atabrin successfully, but both he and his family were hesitant about embarking on a stormy course of nausea and vomiting in the spring of 1938.

At 8 a.m. on April 29, 1938, he had a severe shaking chill, followed by headache, malaise, nausea and vomiting. A blood smear taken shortly afterwards showed the presence of estivo-autumnal crescents. He was admitted to the hospital and ten cc. of prontosil was given intramuscularly at 12, noon. His temperature, which was 104 degrees on admission, came down to normal in the late afternoon. At 8 p.m. on the day of admission the second ten cc. of prontosil was given intramuscularly. During the evening of this day nausea was not present and fluids and soft diet were taken with no difficulty. On April 30 at 9 a.m. the third dose of prontosil was given. During the afternoon of the second hospital day the patient was chilly and the temperature rose to 101 degrees but fell to normal by 8 p.m. when the fourth intramuscular injection of prontosil was administered.

At 8 a.m. on May 1, 1938, the patient had a severe chill, the temperature rising to 104.5 degrees. He became nauseated, vomited and complained of severe malaise. A blood smear taken at approximately the same interval as after the first chill showed many more parasites than were observed at the first examination.

With considerable misgiving treatment was changed to quinine medication, as there was no surety that quinine and prontosil were compatible. However, quinine satisfactorily controlled the disease, with no complications.

Summary: A case of estivo-autumnal malaria was treated with prontosil by a method devised by Hill and Goodwin, and which was reported to give 100 per cent cure. Because this report was published at the end of the 1937 malarial season, and because widespread use may be instituted before full clinical trial can be made of the method, this case is reported as a negative result.

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## ANNUAL CONVENTION— DAYTONA BEACH

The Volusia County Medical Society entertained royally the doctors and guests who attended the Sixty-Sixth Annual Convention of the Association. The meeting this year was held too late to permit the proceedings to be included in this issue of the Journal. The June Journal will contain a complete write-up of the Annual Convention. Members of the Association are urged to read the June Journal carefully and thus become familiar with the actions of the House of Delegates, and General Sessions, as well as reports of committees.

\* \* \*

## MEDICAL DISTRICT MEETINGS

Notice the change of dates. The meetings are to be held on Thursday afternoons, *not Friday*. At a meeting of the Council, held in Daytona Beach May 1, it was decided to hold the annual medical district meetings on Thursday afternoons. Please note this change of dates, set by the Councilors. For the past two years these annual meetings in districts have been held on Thursdays and the same plan will be carried out by the councilors this year.

Each doctor in each district will receive a program prior to his annual meeting. This change, however, is called to the attention of the doctors so that there will be no misunderstanding as to the day of the week on which these district meetings are to be held.

Any member who wishes to read a scientific paper at his district meeting is urged to make application immediately. From applications received four essayists will be selected by the senior councilor in each district. Mail your application to Box 1018, Jacksonville.

\* \* \*

## BASIC SCIENCE BILL

The Senate passed Bill S-35 by a vote of 22 to 15, Tuesday, May 16. The Association's Legislative Committee appreciates the doctors' appeals to their senators for the passage of this bill.

It is hoped that the House of Representatives will pass this bill before the close of the session. The vote should be taken within the next few days. All doctors are urged to familiarize their representatives with the merits of a basic science law. Phone or wire your representative today.

\* \* \*

## FINAL ANNOUNCEMENT OF GRADUATE SHORT COURSE

The program of the Seventh Annual Graduate Short Course for Doctors of Medicine, to be held in Daytona Beach, June 19-24, is presented in detail on page 572 of this issue of the Journal. General information concerning the course will also be found in this issue. Advance registration will be appreciated by the committee. Registration should be handled through Dr. G. C. Tillman of Gainesville.

A few changes were necessary in the program this year. On Thursday, June 22, there will be three lectures in Gynecology while the lectures in Neurology end on Wednesday. The Gynecology lectures end on Friday, though the total number of lectures is the same as in previous years.

No symposia were arranged this year. It was felt that the attendance did not justify the expenditure of last year. On Wednesday evening, June 21, there will be an open meeting of the Duval County Medical Society at Ponte Vedra Beach, to which all physicians attending the Short Course are cordially invited.

## SCHEDULE

Hour	MONDAY June 19	TUESDAY June 20	WEDNESDAY June 21	THURSDAY June 22	FRIDAY June 23	SATURDAY June 24
8:00 a. m.	REGISTRATION					
9:00 a. m.	PEDIATRICS  "Preventive Pediatrics"  DR. DAVISON	PEDIATRICS  "Pneumonia and Empyema"  DR. DAVISON	PEDIATRICS  "Epilepsy and Convulsions"  DR. DAVISON	GYNECOLOGY  "Pelvic Physiology"  DR. CROSSEN	GYNECOLOGY  "Sterility"  DR. CROSSEN	OBSTETRICS  "Treatment of Puerperal Infection"  DR. PRIDE
10:00 a. m.	NEURO- PSYCHIATRY  "Non-Surgical Hemorrhages of the Brain"  DR. TUCKER	NEURO- PSYCHIATRY  "Dysplutiarism"  DR. TUCKER	NEURO- PSYCHIATRY  "Diseases of the Basal Ganglia"  DR. TUCKER	SURGERY  "Pre- and Post- operative Management of Gall Bladder Patients"  DR. McNEALY	SURGERY  "Vitamins in Surgery"  DR. McNEALY	SURGERY  "Surgery of Peptic Ulcer"  DR. McNEALY
11:00 a. m.	RECESS	RECESS	RECESS	RECESS	RECESS	11:00-12:00 OBSTETRICS  "Analgesia, Anesthesia, and Amnesia in Labor"  DR. PRIDE
11:30 a. m.	MEDICINE  "Coronary Thrombosis"  DR. PINCOFFS	MEDICINE  "Thyreotoxycosis"  DR. PINCOFFS	MEDICINE  "Hemorrhagic Diseases"  DR. PINCOFFS	GYNECOLOGY  "Menstrual Disturbances"  DR. CROSSEN	OBSTETRICS  "Conservative Treatment of Abortions"  DR. PRIDE	12:00-1:00 SURGERY  "Surgery of the Large Bowel"  DR. McNEALY
12:30 p. m.	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	
2:00 p. m.	NEURO- PSYCHIATRY  "The Consideration of Alcoholism"  DR. TUCKER	NEURO- PSYCHIATRY  "Manic Depressive Psychosis"  DR. TUCKER	NEURO- PSYCHIATRY  "Paralysis"  DR. TUCKER	OBSTETRICS  "Management of Difficult Labors"  DR. PRIDE	SURGERY  "Injuries to Large Blood Vessels and Their Management"  DR. McNEALY	
3:00 p. m.	RECESS	RECESS	RECESS	RECESS	RECESS	
3:15 p. m.	MEDICINE  "Nephrosclerosis"  DR. PINCOFFS	MEDICINE  "Septicemia"  DR. PINCOFFS	MEDICINE  "Pericarditis"  DR. PINCOFFS	SURGERY  "A Review of the Surgery of Appendicitis"  DR. McNEALY	GYNECOLOGY  "Evaluation of Diagnostic Tests Used in Gynecology"  DR. CROSSEN	
4:15 p. m.	RECESS	RECESS	RECESS	RECESS	RECESS	
4:30 p. m.	PEDIATRICS  "Acute Abdominal Conditions"  DR. DAVISON	PEDIATRICS  "Pediatric Therapy"  DR. DAVISON	OBSTETRICS  "Obstetric Protection"  DR. PRIDE	GYNECOLOGY  "Diagnosis and Treatment of Leucorrhoea"  DR. CROSSEN	OBSTETRICS  "Treatment of Eclampsia"  DR. PRIDE	



## SHORT COURSE NOTES

### MEETING PLACE

All meetings of the Short Course will be held at Beach Rest, which is on the ocean, just off Main Street.

### REGISTRATION

Registration will begin at 8:00 o'clock Monday morning, June 19. Anyone wishing to register ahead of time may do so through Dr. G. C. Tillman, Gainesville. A registration fee of \$5.00 will be charged.

### RECREATION

Daytona Beach was selected for the Short Course because of the varied type of recreation it offers. It is the hope of the Committee that the doctors will bring their families and make the week one of rest and relaxation as well as study. In addition to the attractions of the famous beach, those attending may enjoy golf, and fishing trips may be arranged if desired.

### FACULTY

#### PEDIATRICS

Dr. Wilburt C. Davison, Dean of the School of Medicine and Professor of Pediatrics, Duke University, Durham.

#### NEUROPSYCHIATRY

Dr. Beverley R. Tucker, Professor of Neuropsychiatry, Medical College of Virginia, Richmond.

#### MEDICINE

Dr. Maurice C. Pincoffs, Professor of Medicine, University of Maryland School of Medicine, Baltimore.

#### OBSTETRICS

Dr. W. T. Pride, Professor of Obstetrics, University of Tennessee, Memphis.

#### SURGERY

Dr. Raymond W. McNealy, Associate Professor of Surgery, Northwestern University Medical School, Chicago.

#### GYNECOLOGY

Dr. R. J. Crossen, Assistant Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis.

28 additional deaths were reported as due to paralysis. Fourth on the list was pneumonia with 350 deaths, of which 111 were specified as due to bronchopneumonia. Cancer was reported as the cause of death in 334 cases, while nephritis was reported in 204 deaths.

Classifying the deaths by civil positions, the editorial says that:

"Among the decedents were 206 physicians who were or had been teachers in medical schools, 466 who had served in the World War, 13 veterans of the Civil War and 70 veterans of the Spanish-American War. One hundred and eighty-one were or had been health officers, 151 members of boards of education, 72 members of boards of health and 21 members of state boards of medical examiners. There were 75 who were or had been coroners, 51 mayors, 39 members of state legislatures, 32 authors, 26 bank presidents, 15 pharmacists, 15 members of city councils, 12 editors, 10 postmasters, 10 police surgeons, 8 dentists, 7 missionaries, 5 clergymen, 4 lawyers, 2 justices of the peace, 1 United States Senator, 1 Congressman and 1 judge. There were 21 members of the United States Army Medical Corps, 12 of the United States Navy Medical Corps, 13 of the United States Public Health Service, 13 of the Veterans' Administration and 5 of the Indian Medical Service."

---

## HEART DISEASE STILL IS LEADING CAUSE OF PHYSICIANS' DEATHS

Heart disease was again the leading cause of death, as it has been for many years, of physicians whose obituaries were published in *The Journal of the American Medical Association* in 1938, a summarizing editorial in *The Journal* for April 29 points out.

"The number of obituaries of physicians published in *The Journal* during 1938 was 3,768, including 3,630 of the United States as compared with 3,277 in 1937, also 138 of Canadian physicians," the editorial states.

The average age at death of those classified as of the United States was 65.6, as compared with 65.4 in 1937. The highest number of deaths, 590, occurred between the ages of 65 and 69.

Arteriosclerosis was the second most frequent cause of death, with 442 victims. Cerebral hemorrhage ranked third with 384 deaths;

---

## POSTGRADUATE EDUCATION MUST BE TAKEN TO RURAL PHYSICIANS

Since the people have learned to depend on their physician to such a point that they will not accept a temporary substitute doctor for even a short period, postgraduate medical education in rural communities must be taken to him, Amos Christie, M.D., San Francisco, states in *The Journal of the American Medical Association* for April 29.

He suggests that this may best be done by a full time physician, whom he calls a circuit rider. This term has the connotation of the lawyer who pioneered the West, as did Abraham Lincoln in his day.

"A full time person," he believes, "well trained in a branch of clinical medicine and serving for not longer than two years, could learn much to take back to his medical center and by reason of his academic training could keep the practitioners in the outlying districts

well up on his subject. By traveling from place to place, by knowing local conditions and by possessing factual information and tact, he might be able to raise the standards of medical practice to a high degree. Herein may lie the future of postgraduate medical education.

"There should be a well defined purpose before such a program is initiated. If its aim is to raise the standard of well baby conferences, all efforts should be directed to this purpose.

"The greatest need for postgraduate medical education or refresher courses in pediatrics is felt by men who have been away from medical school more than five years. More time must be allowed for those rural areas in which it is impossible for the physicians to leave their practices for refresher courses. One month or, preferably, two months should be the minimal requirement. The consultant should acquaint himself first with local conditions and the personalities peculiar to the area. In this way he can accomplish more, particularly if the available time is not spread too thinly over too wide an area.

"Choosing the person who is to act as consultant or instructor is most important. Time, thought and energy should be expended on obtaining the best possible physician."

---

#### REPORT OF DISTRICT COUNCILOR FIFTH DISTRICT—

W. McL. SHAW, M. D. .... *Jacksonville*  
NASSAU, CLAY, DUVAL AND ST. JOHNS

The Fifth District comprises the Counties of Duval, St. Johns, Clay, and Nassau. Active medical organizations exist only in Duval and St. Johns Counties. Physicians from Clay and Nassau Counties have joined the organized medical groups of Duval and St. Johns

Counties. One question requiring investigation by the Councilor has been brought to his attention during the year.

Duval County has an active membership of one hundred and sixty-one, being one of the largest societies in the State. Meetings are held on the first Tuesday night of each month. Two members were transferred to other societies during the year. Two members were lost by death. Ten new members have been admitted by election.

The society held nine regular scientific meetings during the year. Guest speakers from other parts of the State included Dr. Frederick K. Herpel of West Palm Beach, Dr. Herbert Bryans of Pensacola, and Dr. J. S. Turberville of Century. The Society is enjoying a healthy growth and the average attendance at the monthly meetings was good during the entire year. Through the generosity of the State Board of Health our monthly meetings have been held in the new auditorium, recently completed, in the State Board of Health Building.

A report of the activities of the St. Johns County Medical Society shows the society had ten regular members during the year; lost one by removal, Dr. R. R. Hilborn, Bunnell, who is now located at Stanfield, N. C.; and added one, Dr. Donald T. Rankin, of Alto, Ga., transferred from Habersham County Medical Society, of Georgia, who is now located at Bunnell, Florida.

Meetings were held regularly during the year, except in July and August, vacation days for most of our members. Meetings were well attended and interesting. All dues were paid and the Society is in good condition, financially.

The Society entertained as guest speakers, Dr. W. A. McPhaul, Florida State Health Officer, and Dr. A. B. McCreary, Director of County Health Units, in April, 1938. Both addressed the Society and urged that a County Health Unit be established in St. Augustine. The addresses were enjoyed and the Society went on record as favoring the establishment of a County Unit. The committee on Public Health and Legislation is making a study of the situation, but nothing definite has been accomplished to date.





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## ATTENTION, COUNTY MEDICAL SOCIETIES

An organization operating under the name of the Florida Society of Sociology and Prophylaxis, 424 American Bank Building, Miami, has obtained the endorsement of a number of medical societies throughout this State. It appears from information received from the American Medical Association's Bureau of Investigation that the organizers of this Society have been operating various rackets for many years. The organizers of the Florida Society of Sociology and Prophylaxis bear a questionable reputation with the American Medical Association, from whom information can be obtained regarding their previous activities.

\* \* \*

## STATE NEWS ITEMS

Dr. Herbert L. Bryans of Pensacola was elected president of the local Rotary Club in March. Another of the State Medical Association's past presidents has thus been honored.

\* \* \*

The 24th Annual Meeting of the American Association of Industrial Physicians and Surgeons and Industrial Hygiene will be held at the Hotel Statler, Cleveland, Ohio, June 5, 6, 7, and 8. A program of timely interest and importance will be presented by speakers of outstanding experience in all of the medical and engineering problems involved in industrial health. A cordial invitation is extended to all whose interests bring them in contact with these problems. Information regarding hotel accommodations, etc., may be obtained from A. G. Park, Convention Manager, 540 North Michigan Avenue, Chicago.

\* \* \*

The International Association of Milk Sanitarians, Inc., will hold its 28th Annual Meeting in Jacksonville at the Hotel Mayflower, October 25, 26 and 27. This organization is composed of dairy scientists, milk control officials and leaders of the dairy industry. It publishes the Journal of Milk Technology and promotes sound dairying by encouraging the adoption of improved methods and the employment of competent personnel. It is believed the meeting will be of interest to physicians and a cordial invitation is given them to attend the sessions.

The last of the dramas in the series of weekly radio programs by the American Medical Association and the National Broadcasting Company will be presented during June and will deal with the general subject "Using Health Knowledge." This program will be broadcast over the Blue network of N. B. C. each Wednesday, at 2 P. M. *c. s. t.*, as follows:

May 31—Checking Up on Health.  
June 7—Vacations—Why and How.  
June 14—Never Stop Learning.  
June 21—Answering Your Questions.

\* \* \*

Dr. Marshall Faver of Miami is taking a postgraduate course in ophthalmology at the George Washington University, Washington, D. C.

\* \* \*

At the health institute held in Orlando, March 31, the following doctors appeared on the program: Dr. H. Marshall Taylor of Jacksonville; Drs. W. Henry Spiers, Carl D. Hoffmann and W. E. Sinclair of Orlando. The institute was held at the Memorial Junior High School auditorium under the sponsorship of the Woman's Auxiliary of the Orange County Medical Society.

\* \* \*

Dr. R. C. Woodard, superintendent of the James M. Jackson Memorial Hospital at Miami, appeared on the program of the Southeastern Hospital Conference in Jacksonville, the early part of April. The subject of Doctor Woodard's paper was "Progress of Group Hospitalization."

\* \* \*

Dr. F. Clifton Moor of Tallahassee, newly elected city commissioner, was guest speaker on April 6 at a general meeting of the Tallahassee Woman's Club. His subject was "Cancer Control."

\* \* \*

Dr. Thomas E. Buckman of Jacksonville, president of the Duval County Medical Society, gave the opening address at a health institute held in the State Board of Health Building and sponsored by the Woman's Auxiliary of the Duval County Medical Society, on April 5. Other speakers and their subjects were:

Dr. L. H. Kingsbury of Orlando, "Tuberculosis"; Dr. K. K. Waering of Jacksonville,





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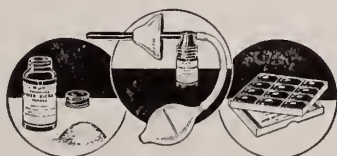
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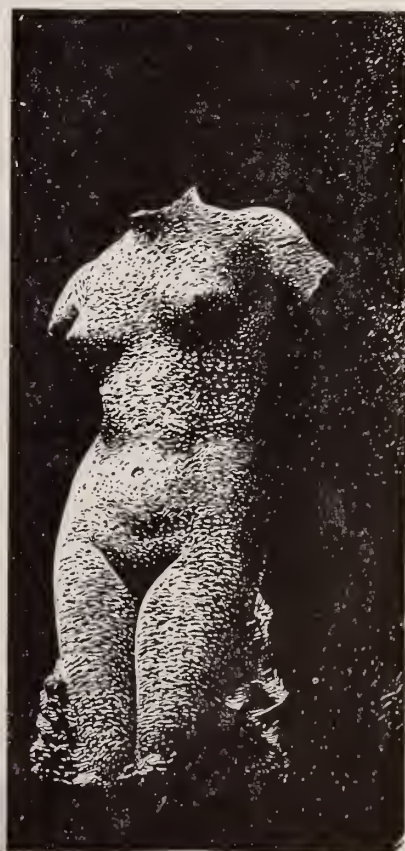
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"Public Health"; Dr. Edward Jelks of Jacksonville, "Socialized Medicine"; Dr. Louie Limbaugh of Jacksonville, "Diabetes"; Dr. B. F. Woolsey of Jacksonville, "Venereal Diseases," illustrated with slides; and Dr. Harold D. Van Schaick of Jacksonville, "Cancer."

\* \* \*

The following Florida doctors attended the annual meeting of the American College of Physicians, held in New Orleans, March 27-31: Dr. J. Sudler Hood, Clearwater; Dr. Theodore F. Hahn, DeLand; Drs. J. L. Borland, T. Z. Cason, Stanley Erwin and Louie Limbaugh, Jacksonville; Dr. Kenneth Phillips, Miami; Drs. Meredith Mallory and Fred Mathers, Orlando; and Dr. Herbert L. Bryans, Pensacola.

\* \* \*

The annual meetings in the six medical districts will be held on Thursdays. Early publications designated Fridays. At a meeting of the Council, held in Daytona Beach in May, it was officially decided to continue the annual medical district meetings on Thursdays. Please note the change of date and make your plans to attend your medical district meeting this year.

## SCHEDULE



Marianna (A) . . . . .	July 20
Palatka (C) . . . . .	Sept. 14
Lakeland (D) . . . . .	Sept. 28
West Palm Beach (F) . . . . .	Oct. 12
Ocala (B) . . . . .	Oct. 26
Sanford (E) . . . . .	Nov. 9

\* \* \*

Dr. Jack Humphreys announces the opening of his office at 8024 N. E. Second Avenue, Miami, for the practice of medicine and surgery.

\* \* \*

## BIRTHS AND MARRIAGES

## BIRTHS

Dr. and Mrs. Arthur J. Bieker of St. Petersburg announce the birth of a son on April 26.

\* \* \*

Dr. and Mrs. Jack Humphreys of Miami announce the birth of a daughter, Mary Nodan, on April 7.

## MARRIAGES

Dr. Archie J. Baker and Miss Nettalein Leitner of Jacksonville were married April 22.

\* \* \*

Dr. William H. Ball of Panama City and Miss Lucile Mercedes Clarke of Dothan, Alabama, were married on May 15.

FOR SALE: Because of failing health from diabetic gangrene am forced to abandon a lucrative practice of 10 years' duration. Whole house, 11 rooms; also some equipment. For further particulars address B. F. Eckman, M.D., 2717 Ponce de Leon Blvd., Coral Gables, Florida.

## COMPONENT COUNTY SOCIETIES

## DADE COUNTY MEDICAL SOCIETY

The April meeting of the Dade County Medical Society was held on the evening of the 4th at the Ingraham Building. The scientific program consisted of two papers. One was by Dr. Theodore M. Berman on "Roentgen Diagnosis of Intra-Abdominal Extra-Gastro-Intestinal Masses," illustrated by lantern slides. Dr. Frazier J. Payton led the discussion. Dr. George N. MacDonell, city health officer, presented "Yellow Jack," which was discussed by Dr. Charles L. Williams, Assistant Surgeon General of the U. S. P. H. S.

\* \* \*

## DUVAL COUNTY MEDICAL SOCIETY

The regular meeting of the Duval County Medical Society was held April 4 in the library of the Board of Health Building at 8:15 p. m., Dr. Thomas E. Buckman presiding. The scientific program was in charge of Dr. George W. Croft and an interesting paper entitled "Epilepsy from the Neurological Surgical Standpoint" was given by Dr. J. G. Lyerly. The business meeting followed and the society went on record as unanimously favoring the proposed Basic Science Law.

The following were elected to the House of Delegates of the Florida Medical Association for the meeting to be held in Daytona Beach: Delegates: Drs. J. L. Boone, Robert B. McIver, L. Y. Dyrenforth, H. Marshall Taylor, Frederick J. Waas, S. E. Driskell, E. T. Sellers and Thomas E. Buckman; Alternates: Drs. Alan Brown, Luther W. Holloway, W. McL. Shaw, Gordon H. Ira, Charles B. Mabry, J. B. Black, H. B. McEuen and Herman Brooks.

\* \* \*

## FRANKLIN-GULF COUNTY MEDICAL SOCIETY

The Franklin-Gulf County Medical Society, youngest in the Association, is on the honor roll of 100% paid societies. Dr. Chapman Dykes of Carrabelle is president and Dr. A. L. Ward of Port St. Joe is secretary of this society.





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## PALM BEACH COUNTY MEDICAL SOCIETY

The Palm Beach County Medical Society, embracing a membership of 58, is a 100% paid society. This active organization is this year headed by Dr. R. Gaylord Lewis, president; G. W. Heath, vice president; C. Jennings Derrick, secretary; and Frederick K. Herpel, treasurer.

\* \* \*

## PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. W. Wardlaw Jones entertained the Pasco-Hernando-Citrus County Medical Society at the Edwinola Hotel in Dade City, Thursday evening, April 13, 1939.

The society received a letter from Senator George A. Dame, regretting his inability to attend the meeting, and the secretary was instructed to write Doctor Dame expressing regret of his absence.

More time was asked by the Board of Trustees to get the Society incorporated.

All members present gave very interesting reports of clinical cases.

Dr. Sistrunk invited the Society to hold its next meeting with him in Dade City, May 11, 1939.

Those present were: Drs. J. T. Bradshaw, C. L. Carter, G. R. Creekmore, W. W. Jones, S. C. Harvard, H. L. Harrell, P. J. Hudson, D. B. Manley, and R. D. Sistrunk.

The Pasco-Hernando-Citrus County Medical Society has a more scattered membership than any other society of its size in Florida. The 15 members of this organization are drawn from eight cities. That this society is again 100% paid indicates a well-organized, cooperative group. Dr. Claude L. Carter of Inverness is president; Dr. H. L. Harrell of Dade City and Dr. A. C. Coogler of Brooksville vice presidents; and Dr. G. R. Creekmore of Brooksville, secretary and treasurer.

\* \* \*

## PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society now holds the honor of being the largest 100% paid unit in the Association. Ninety-one active and one honorary member constitute this society which is this year under the direction of Drs. E. C. MacCordy, president; N. W. Gable,



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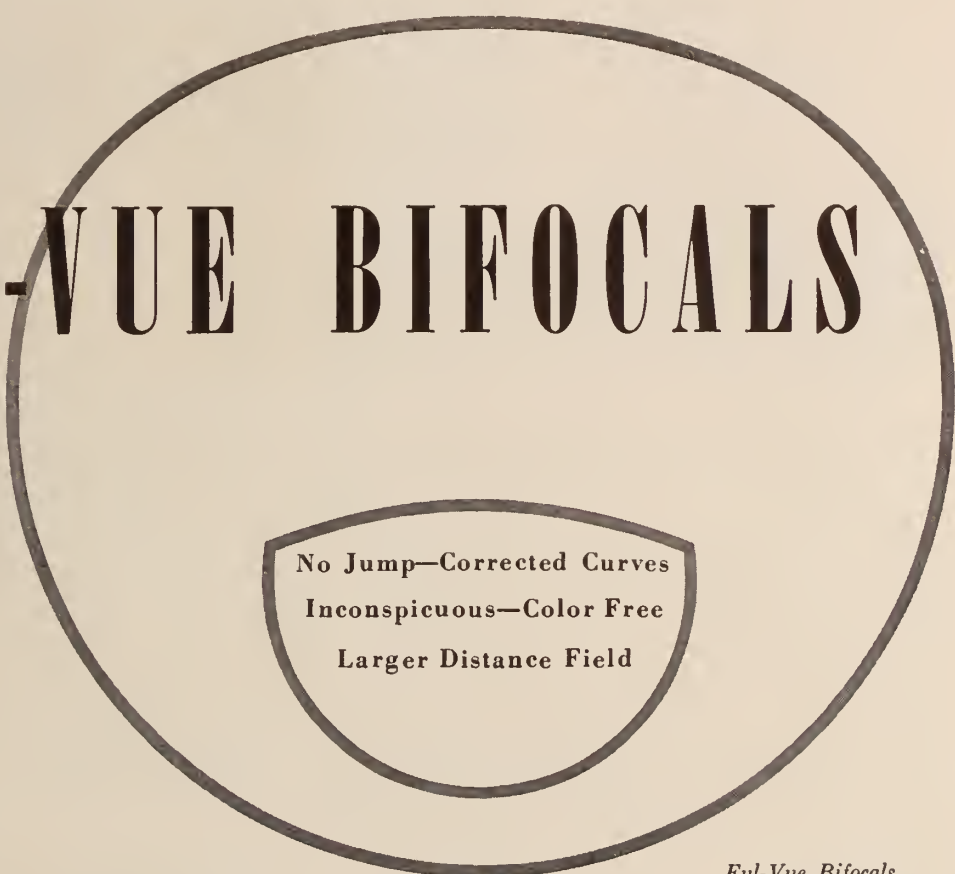
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At the April 7 meeting of the Pinellas County Medical Society, Dr. D. F. H. Murphy of St. Petersburg was principal speaker, presenting a paper on "Treatment of Meningococcus Meningitis."

The following resolution was recently passed by the Pinellas County Medical Society in connection with the death of Dr. Andrew P. Albaugh, an honorary member of the Society:

WHEREAS, God in all His wisdom has seen fit to withdraw from our midst our beloved colleague and brother, Doctor Andrew P. Albaugh, who for over fifty years has unselfishly and with great devotion served his fellow men, and

WHEREAS, Doctor Albaugh was a charter member and a past president of the Pinellas County Medical Society and at the time of his death was the oldest member of the organization, remaining actively engaged in practice until only a few days before his death on Thursday, March 16; and

WHEREAS, His life was a full and exemplary one. Besides his work in the medical profession, he was a valued leader in civic, church and school affairs as well. Born June 23, 1862, at Kilgore, Ohio, Dr. Albaugh received his education at Ohio Northern and later attended Miami Medical College at Cincinnati, receiving his medical degree from this college in 1887. Ten years later he moved with his family to Tarpon Springs and soon became one of the municipality's foremost citizens. He served several years as president of the city council and at the time of his death he was city health officer. He had also served as a member of the local school board, as chairman of two Liberty Loan drives and during the World War was local chairman of the Red Cross. For forty years he had been actively engaged in the work of the Trinity Methodist Church and resigned as teacher of the adult Bible class only last Saturday. In 1900 he became local surgeon for the Atlantic Coast Line Railroad, resigning this position two years ago but continuing in honorary standing. In 1905 he was appointed local observer for the U. S. Weather Bureau and only a short time ago he was congratulated by the chief of the bureau for his long and faithful service. Among other organizations with which he was affiliated were the Masonic Lodge, the Knights of Pythias and the Woodmen of the World.

THEREFORE, Be it so ordered by vote of this society that this resolution be spread upon the minutes of this meeting, a copy sent to the widow and another copy sent to the Journal of the Florida Medical Association for publication.

Respectfully submitted,

C. B. WRIGHT, M. D., Chairman  
E. A. HEIBNER, M. D.  
R. K. O'BRIEN, M.D.

\* \* \*

#### TAYLOR COUNTY MEDICAL SOCIETY

The Taylor County Medical Society has selected as its officers for the current year: president, Dr. George H. Warren; vice-president, Dr. J. L. Weeks; secretary-treasurer, Dr. Ralph J. Greene. This society has a membership of 8.

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## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Ineffectiveness of Sulfanilamide in Rabies from Vaccinated Dogs, HART, BENJAMIN, and EVANS, ELWYN, Winter Park, J. A. M. A. 112: 731-732 (Feb. 25), 1939.**

In an exceptionally interesting and concise report, the authors describe a case of rabies, treated in the usual manner with the addition of adequate doses of sulfanilamide, with no apparent influence on its termination. The patient was bitten by a dog which had been given the 1 dose method of rabies vaccination. His own dog, which had also received this method of vaccination, was bitten at the same time and later developed rabies; hence their conclusions are that this method of vaccination for dogs is unreliable and that sulfanilamide has no effect on the disease in the human.

**The Clinical Value of Quantitative Blood Studies in the Management of Syphilis, including Fever Therapy, PHILLIPS, KENNETH, and LITTERER, A. BUIST, Miami, Urol. & Cutan. Rev. Vol. 43, No. 1 (1939).**

The authors emphasize the necessity for more accurate serological evidence of improvement in syphilitics under therapy than that accorded by the ordinary qualitative tests and for this purpose utilize the quantitative Kline test which provides an arbitrary measurement of the potency of syphilitic serums in terms of reacting substances or Kline units. Thus, even though the qualitative test may remain strongly positive, a decline in the number of Kline units gives definite evidence of a favorable response to the particular antisyphilitic treatment.

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Mrs. FRANK D. GRAY, South Central "E".....Orlando  
Mrs. H. A. LEAVITT, Southeast "F".....Miami

In this issue of the Journal we are making our official bow and bid for your approval.

In assuming the duties as President of this organization with its splendid women, I am deeply conscious of the fact that while it is a great privilege, it is also a great responsibility. I appreciate the honor which has been bestowed upon me, and I trust that I shall always prove its worth.

Each member of our organization either adds to or subtracts from the general status of our work so won't you all pledge anew your own support so we will forge ahead this noble work already begun by my worthy predecessors.

May we all sustain a local pride, a state pride, and a national pride, and all join together in making this Florida "Our Florida, the Beautiful."

Sincerely yours,

(Mrs. L. C.) CAROLYN F. INGRAM.

The President having divided the State Auxiliary into the same districts as the Medical Association, conferences are planned to be held at the same time as the doctors have their district meetings. Each District Chairman, with the two Councilor doctors, will have charge of these meetings in her district.

Health Education will again be the main objective of the Auxiliary. Essay contests will be held in the schools; health institutes and Health Day programs in organizations such as women's clubs and parent-teacher organizations.

During the recent annual meeting of the Auxiliary, delegates and alternates were elected to the National Convention to be held in St. Louis, May 15 to 19, as follows: Delegates—Mrs. L. C. Ingram, Orlando; Mrs. Gordon Ira, Jacksonville; Mrs. F. W. Krueger, Jacksonville. Alternates—Mrs. Chas. Collins, Orlando; Mrs. Gerard Raap, Miami; Mrs. R. M. Harris, Miami.

The following tribute is published in token of our deep regret at the death on October 18, 1938, of Mrs. Mitchell Moran, the wife of Dr. Mitchell Moran of St. Petersburg, Florida, and Buffalo.

### IN LOVING MEMORY OF MRS. ELIZABETH MORAN

WHEREAS, God in His wisdom has summoned the sweet spirit of our sister and co-worker, Elizabeth Moran, from her earthly home to her Heavenly one; and

WHEREAS, We, the members of the Woman's Auxiliary to the Florida Medical Association are grateful to our Heavenly Father for her useful life with its benediction of precept and example, that she so ably used as one of our members; therefore be it

RESOLVED, That we bow in humble submission to the divine decree that took her from our midst and the labor she loved, to a more perfect service above; that we cherish her memory and ever keep before us as most worthy of emulation, the example of her faith, loyalty and patience; and that we extend our heartfelt sympathy to the sorrowing husband and family; and be it further

RESOLVED, That a copy of these resolutions be sent to the bereaved husband and family and also be inscribed in a page of our Minutes and Scrapbook, and that a copy be sent to the Florida Medical Journal for publication.

"So when today becomes yesterday,  
And you lie down to rest,  
May we be able to truthfully say  
God doeth all things for the best."

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245 ☐

N. Y. State Jour. Med. 1935, 35-No. 11,590 ☐

Laryngoscope, 1935, XLV, 149-154 ☐

Laryngoscope, 1937, XLVII, 58-60 ☐

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Dis- tricts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not In- cluded in First Column	Members	
						Total	Paid
Northwest District (A) Marianna July 26, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	12	100%
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. DeSoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	33
	Walton-Okaloosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Ramsey, M.D. Noma	L. H. Paul, M.D. Bonifay		Santa Rosa	8	7
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. L. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'41 B. A. Wilkinson, M.D. Tallahassee	6	100%
	Jackson	C. J. Price, M.D. Alford	It. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		14	12
	Leon-Gadsden-Liberty- Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Gulney	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	39	33
North Central District (B) Ocala October 26, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'41 W. A. Nichols, M.D. Lake City	21	16
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Geo. H. Warren, M.D. Perry	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton- Lafayette-Suwannee	8	6
	Alachua	J. E. Maines, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St., S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	28	21
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		23	100%
	Pasco-Hernando- Citrus	Clsude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	100%
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	Bradford-Gilchrist- Levy-Union	3	2
N. E. District (C) Palatka September 14, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'41 R. B. McIver, M.D. Jacksonville	172	166
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	10	9
	Volusia	Maxmillan Stern, M.D. Box 5098 Daytona Beach	R. L. Miller, M.D. 258 1/2 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	41	37
Southwest District (D) Lakeland September 28, 1939	Hillsborough	J. W. Alsbrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M. D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'41 W. C. McConnell, M.D. St. Petersburg	108	87
	Manatee	S. G. Hollingsworth, M.D. 451 12th St. Bradenton	M. M. Harrison, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P. M.		13	100%
	Pinellas	E. C. MacCordy, M.D. 366 First Federal Bldg. St. Petersburg	W. C. McConnell, M.D. 1001 First Federal Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		92	100%
	Sarasota	T. W. Taylor, M.D. Professional Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	10
	DeSoto-Hardee-High- lands-Charlotte- Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M.D. Lakeland	19	100%
	Lee	C. Gordon Merrick, M.D. 26 Leon Bldg. Fort Myers	H. L. Allan, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		14	11
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	62	100%
South Central District (E) Sanford November 9, 1939	Brevard	W. J. Creel, M.D. Eau Gallie	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	11	7
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	13
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		77	72
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Douglas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'41 A. M. Sample, M.D. Ft. Pierce	17	100%
	Broward	R. L. Elliston, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	33	100%
	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Box 574 W. Palm Beach	4th Monday 8:00 P. M.		58	100%
S. E. District (F) West Palm Beach October 12, 1939	Dade	M. Jay Flipse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'41 Kenneth Phillips, M.D. Miami	291	230
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	100%



STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Leigh F. Robinson, Ft. Lauderdale	Shaler Richardson, Jacksonville	Tampa, 1940
Florida Medical Districts:			
A—Northwest	Carol C. Webb, Pensacola	Stewart Thompson, Jacksonville	Marianna, July 20, 1939
B—North Central	J. L. Strange, McIntosh	" " "	Ocala, Oct. 26, 1939
C—Northeast	George M. Green, Daytona Beach	" " "	Palatka, Sept. 14, 1939
D—Southwest	Herman Watson, Lakeland	" " "	Lakeland, Sept. 28, 1939
E—South Central	W. C. Page, Cocoa	" " "	Sanford, Nov. 9, 1939
F—Southeast	Lloyd J. Netto, West Palm Beach	" " "	West Palm Beach, Oct. 12, 1939
Alabama Medical Association	Seale Harris, Montgomery	D. L. Cannon, Montgomery	
Georgia Medical Assn. of	Grady N. Coker, Canton	E. D. Shanks, Atlanta	
Florida—			
State Dental Association	R. P. Taylor, Jacksonville	E. C. Lunsford, Miami	West Palm Beach, Oct. 12-14, 1939
Soc. of Derm. and Syph.	Elmo D. French, Miami	Lauren Sompayrac, Jacksonville	
East Coast Medical Association	Frederick J. Waas, Jacksonville	A. J. Logie, Jacksonville	Jacksonville, 1939
State Hospital Association	J. H. Therrell, Chattahoochee	Mr. Fred Walker, Jacksonville	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Daytona Beach, June 19-24, 1939
State Nurses Association	Mrs. Inez Nelson, Orlando	Mrs. Phyllis Leonard, St. Augustine	Lakeland, Nov. 6-8, 1939
Pediatric Society	Gilbert S. Osincup, Orlando	Warren Quillian, Coral Gables	Tampa, 1940
Pharmaceutical Association	Mr. R. Q. Richards, Ft. Myers	Mr. A. W. Morrison, Miami	Hollywood Beach, May, 1939
Public Health Association	Mr. S. D. Macready, W. P. Beach	E. M. L'Engle, Jacksonville	Jacksonville, 1939
Radiological Society	H. O. Brown, Tampa	J. H. Lucinian, Miami	Tampa, 1940
Railway Surgeons Association	Herman Watson, Lakeland	H. D. Clark, Ft. Pierce	Tampa, 1940
Tuberculosis & Health Assn.	Mr. G. E. Therry, W. Palm Beach	Mrs. May Pynchon, Jacksonville	
Chattahoochee Valley Med. Assn.	J. S. Turberville, Century	Frank K. Boland, Atlanta	Albany, Ga., July 11-13, 1939
East Coast Clinical Society	J. H. Dodson, Mobile	C. C. Rouse, Mobile	Mobile, 1939
Internat. Assn. Milk Sanitarians	Mr. V. M. Ehlers, Austin, Texas	Mr. C. Sidney Leete, Albany, N. Y.	Jacksonville, Oct. 25-27, 1939
Southeastern Derm. Assn.	J. R. Allison, Columbia	Howard King, Nashville	Nashville, Sept. 3, 1939
Southeastern Surgical Congress	R. L. Sanders, Memphis	B. T. Beasley, Atlanta	Birmingham, Mar. 11-13, 1940
Western Medical Association	W. E. Vest, Huntington, W. Va.	Mr. C. P. Loranz, Birmingham	Memphis, Nov. 21-24, 1939
Wansee River Medical Society		Eustace Long, Madison	

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# The JOURNAL

of the

## Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

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#### NEXT SESSIONS

American Medical Association, New York, June 10-14, 1940  
Florida Medical Association, Tampa, 1940  
Southern Medical Association, Memphis, November 21-24, 1939



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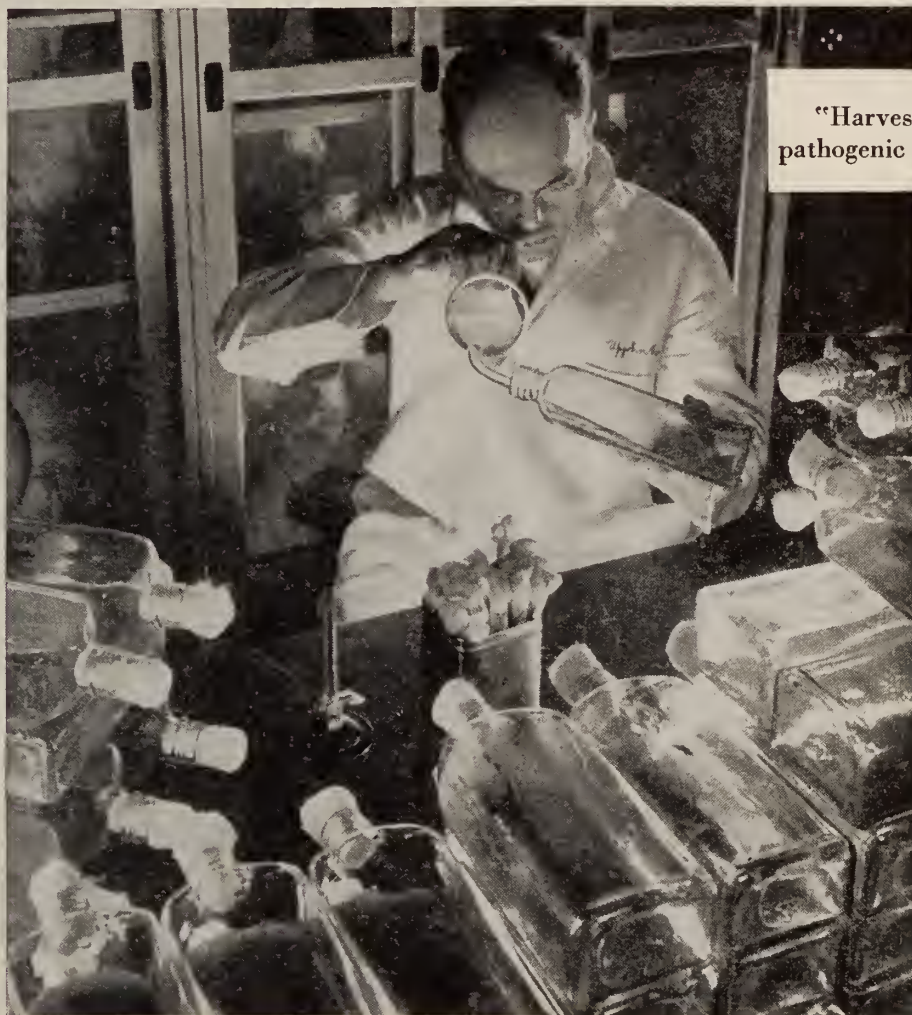




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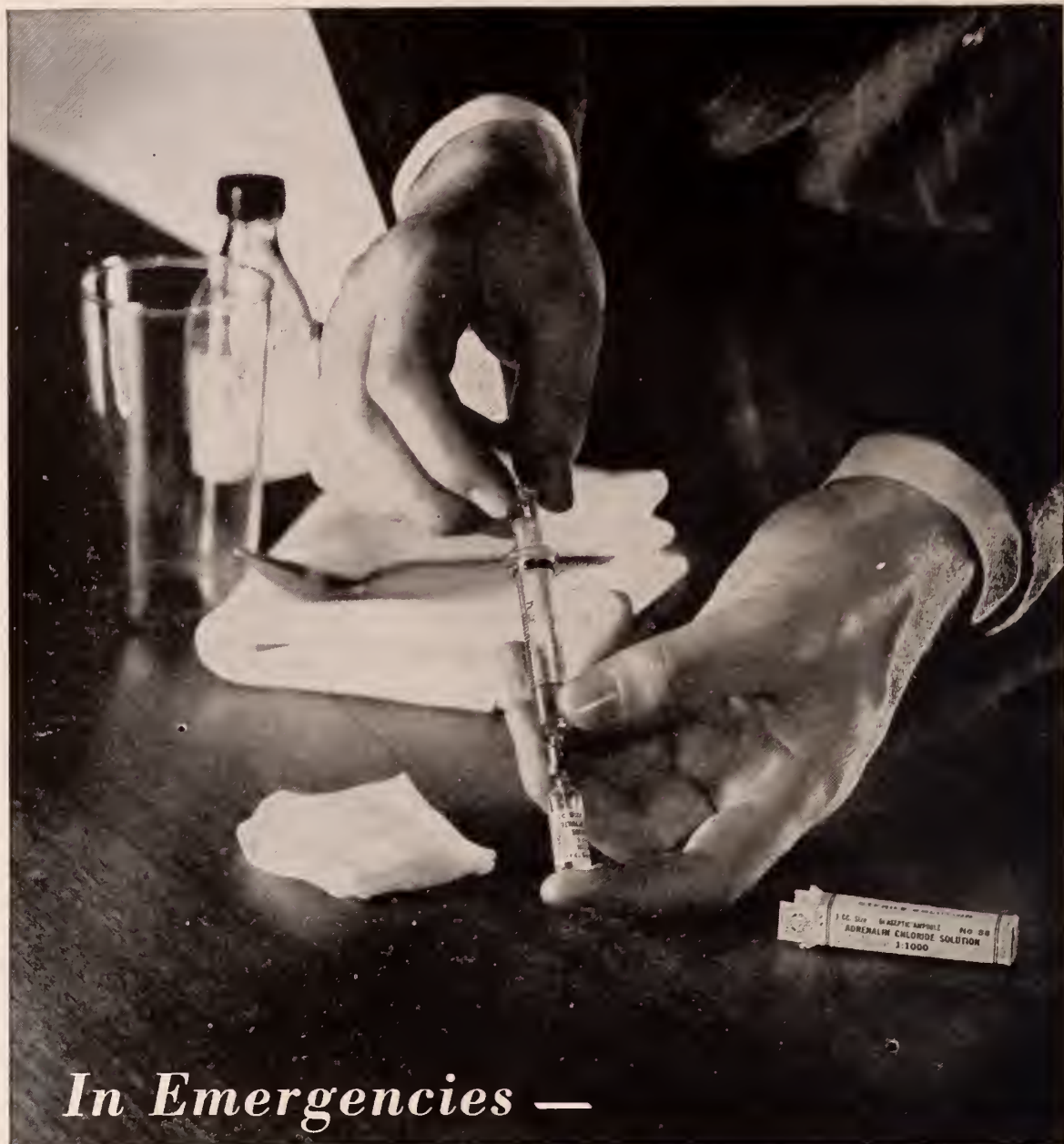
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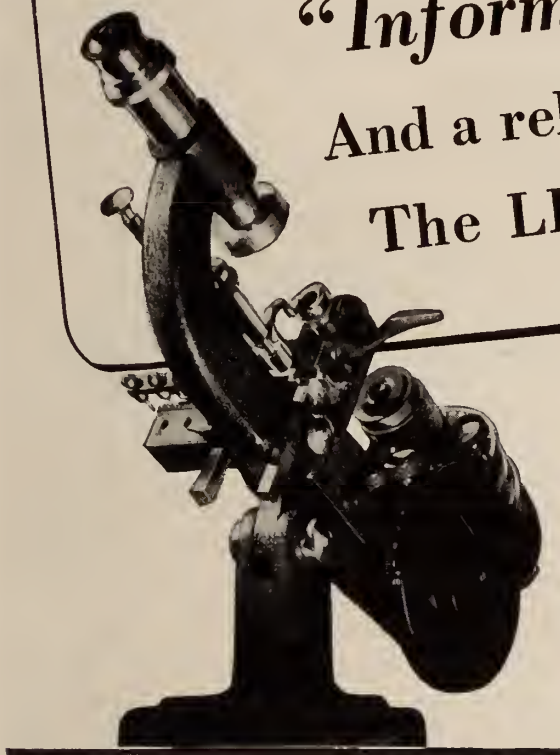
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\*Further Clinical Observations on Feeding Infants Whole Milk, Gelatinized Milk, and Acidified Milk. C. Loring Joslin, M.D., F.A.A.P.; Bulletin of the School of Medicine, University of Maryland; Jan. 1939.

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## President's Address

W. HENRY SPIERS, M.D.

Orlando

Let us think for a moment of medicine's gifts to mankind. From its very beginning the science of medicine has contributed vastly to the happiness of human beings. From the beginning of civilization it has been the purpose of the medical doctors to eventually free mankind of the greatest tyrant he has ever known, the tyrant of fear; and of all fears which disturb mankind the greatest is the fear of pain, suffering, disease, and death. In an earlier period in the history of man, hundreds of thousands of human beings were destroyed by disease and by great plagues which swept across the world. Today the people who live in civilized communities no longer fear smallpox, typhoid, yellow fever, bubonic plague, cholera, leprosy, or even syphilis. One by one the causes of the infectious diseases have been discovered, the means of transmission have become known, and those diseases have been brought under control.

Before the time of Pasteur, surgery was limited to just a few simple operative procedures, including amputation of limbs. There were but few physicians competent to invade the interior of the human body. Then came our understanding of the germ causation of disease, and the demonstration by the famous Lister of the possibility of eliminating infection. Before our knowledge of the germ causation of disease and before the introduction of antiseptics and of aseptic methods, surgery was viewed with horror by every person confronted with the necessity of an operation. Forty-five per cent of amputations resulted fatally. Hospitals were filled with the smell of the pus, the decay, and the inflammations of infected wounds. Today there is no portion of the human body which the surgeon does not invade; lives are greatly prolonged; the operating room is a clean refuge for those who require its service.

Life expectancy of man at birth in the United States has moved up from an earlier

35 years to almost 61 years, and it is conceivable, with suitable application of what medicine now knows in relation to the control of the degenerative diseases, that life expectancy may be advanced an additional five years. The medical doctor has cooperated with health departments, with authorities in schools and with newspapers, radio networks, and other means of public information to spread widely the knowledge of the nature of disease and the methods of prevention. Thus the medical doctor is perhaps the only worker in all the world who spends most of his time destroying the conditions by which he has gained his livelihood. Vast numbers of people now share the knowledge of medicine, which is no longer held a mystery. The frontiers of medicine are constantly changing. Medicine is a living, vital science, constantly moving to attack new problems that arise. It has given vastly of itself to mankind in the past, and it stands ready to give more, if it can, in the future. It makes to mankind no promise of immortality or even of eternal youth; but it does offer to those who are ready to receive its gifts, increasing years of usefulness.

We, as the members of our local societies, our State Association, and the National Association, are carrying on, to the best of our abilities, this progress of medicine in making life more worthwhile to mankind. It is our duty as a profession to forget self and work for the good of our fellow man.

In the discussions as to whether the practice of medicine is a profession or a trade and in the considerations of new methods of supplying medical service, many fail to evaluate properly the nature of the doctor's work. Some years ago the Commission on Medical Education, which was a representative group including leading educators and medical doctors, made an analysis of the daily work of a doctor in an average American community. The results of that study showed that the doctor is not governed by the usual rules having to do with hours of work, leisure time, routine character of employment or any of the other

factors which are so easily regulated for workers in business or in trades. For instance, 500 doctors who had been out of school for from five to thirteen years and who were doing what is called a general practice in towns of 50,000 population or less in twenty-four of the United States and in two provinces of Canada were asked to submit samples of their daily work. Each gave a list of the patients he had, and the diagnoses of the conditions from which these patients suffered.

First, it was found that 55 per cent of the practice of the doctor was carried on in his office, 35 per cent was attended to in the patient's home and the remaining 10 per cent was carried on in the hospital. Seventy-five per cent of the office visitors were treated for infections of the nose, throat and lungs, such as the common cold and sinus infections, for general "medical" disorders, for conditions requiring minor surgery and for venereal diseases. About 90 per cent of the visits made to the patients in their homes were for contagious diseases, for childbirth, and for conditions requiring minor surgery. In the hospital, on the contrary, 50 per cent of the visits were made for "surgical" conditions and 15 per cent for childbirth. With this variation in the nature of the services to be rendered and in the characteristics of the people attended, a wide variety of problems must be met by the doctor. Obviously, it is not possible to standardize medical practice as one might standardize the building of a motor car, salesmanship in a department store, or almost any other of the ordinary occupations of mankind.

In meeting the needs of sick people the doctor must have judgment, insight and resourcefulness. He has to understand the entire problem of each patient, realizing that no two patients are alike. He must treat every individual according to that individual's needs at the time when that individual wants him. If a woman pinches her finger in a door at 2 o'clock in the morning, she does not want a doctor who rings in on a clock at 8 in the morning. If a man is seized with a sudden severe spell of vomiting at 10:30 at night, he does not want to call a salaried doctor whose hours of work are from 9 in the morning until 3:30 in the afternoon. Medical work is, therefore, as much an emergency occupation as is that of the fireman, who may be idle six hours of the day and ready to hazard his life

in the seventh. Yet the fireman is dealing with materials primarily and with the saving of these materials from destruction, while the doctor is dealing with an intangible known as human life, which, once destroyed, cannot be restored. The physician stands between death and the patient, carrying on a warfare against an enemy that threatens constantly and that knows no fixed hours of attack.

In the attempt to solve the problem of medical care for all the people, it has been suggested that a salaried medical profession, whether employed by the government, a corporation, a cooperative group, or under any other circumstances, would answer the problem for the American people satisfactorily and would give them the kind of professional service that they have been used to having. There is every evidence that this contention cannot be sustained. When the doctor's practice becomes standardized to hours of work and to his needs rather than to the needs of the patient, the quality of medical practice will inevitably suffer.

All the hopes and despairs of man,—happiness, unhappiness, honor,—are subjects to occupy the medical faculty; birth, life, suffering, death fall within its province. It is rightly said that a doctor must know something of every calling if he is to understand his own properly. In order to understand man and all his trials and difficulties, the medical man must study humanity, must take life as a whole, must look upon the individual as a link in the continuity of life. In this way he develops from being the counselor of the sick to being the guide of the healthy.

If medicine proposes to pilot man through life, it must understand his organism. It must get clear as to his position in the general scheme of things by the study of biology; it must learn his structure and his functions by working at anatomy and physiology; and since the diseases of men are also included among his functions—though they are inverted ones—pathology must also form a section of its researches. If the telephone, the underground railway and the wireless were evolved as by-products—the interest for bacteria leads to the discovery of cures for the diseases caused by them—so much the better. The aim, however, must ever be to try to raise the veil concealing the mysteries; even though, perhaps all the more though, nothing lies beneath but man himself.



The more I think of our proposed Basic Science Law the greater is my respect for what it will accomplish in protecting the public health of our state. I am also confident that, if all our state senators and representatives in the legislature now in session at Tallahassee, were familiar with every phase of the bill, opposition to it would be practically nil. There is nothing in it that discriminates against any healing method.

The medical doctors of this state who are members of this Association have always supported laws to improve health conditions. We have no selfish motive and, because of this, will eventually convince the public and our law makers that what we seek medically is only for the public benefit.

One of the most powerful agencies at our disposal is our public relations facilities.

Through this we can impart proper medical information to the people by radio, talks to various civic organizations, and educational bodies. The work we have done along this line already has demonstrated its value.

The medical doctors receiving their diplomas this year are better trained than those of a few years back. This improvement in the standards of qualifications in our profession is perpetual and, as long as we maintain these standards, I have no fear about the future of medicine as it has come to us throughout the ages.

We must, however, assist the public in correcting adverse conditions pertaining to health. Therefore, it is necessary that we continue a legislative and educational program to this end.

*Box 2339.*

---

# PROCEEDINGS

*of the*

## SIXTY-SIXTH ANNUAL MEETING

*of the*

### FLORIDA MEDICAL ASSOCIATION, INC.

#### HELD AT DAYTONA BEACH, FLORIDA

#### MAY 1, 2 and 3, 1939

#### FIRST MEETING OF HOUSE OF DELEGATES

The House of Delegates convened at 9:00 a. m., Monday, May 1, 1939, at the Inn Dining Room of the Princess Isseña Hotel, Daytona Beach, Florida, with Dr. W. Henry Spiers, president, presiding.

The following delegates were seated:

#### DELEGATES

ALACHUA COUNTY MEDICAL SOCIETY:  
J. L. Summerlin

BAY COUNTY MEDICAL SOCIETY:  
William C. Roberts

BREVARD COUNTY MEDICAL SOCIETY:  
T. C. Kenaston

BROWARD COUNTY MEDICAL SOCIETY:  
E. M. Hendricks H. J. Peavy

COLUMBIA COUNTY MEDICAL SOCIETY:  
T. H. Bates

DADE COUNTY MEDICAL SOCIETY:  
W. C. Jones  
Jos. Stewart  
A. H. Weiland  
M. M. Coplan  
Homer Pearson  
C. E. Dunaway

F. J. Payton  
H. A. Walker  
K. Phillips  
E. D. French

#### DUVAL COUNTY MEDICAL SOCIETY:

J. L. Boone  
R. B. McIver  
L. Y. Dyrenforth  
F. J. Waas  
E. T. Sellers  
T. E. Buckman  
Gordon Ira

#### ESCAMBIA COUNTY MEDICAL SOCIETY:

L. C. Fisher J. S. Turberville

#### FRANKLIN-GULF COUNTY MEDICAL SOCIETY:

Chapman Dykes

#### HILLSBOROUGH COUNTY MEDICAL SOCIETY:

W. M. Rowlett  
H. Mason Smith  
J. C. Vinson

#### LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY:

J. C. Robertson B. A. Wilkinson

#### MANATEE COUNTY MEDICAL SOCIETY:

T. M. McDuffee

#### MARION COUNTY MEDICAL SOCIETY:

R. D. Ferguson

#### ORANGE COUNTY MEDICAL SOCIETY:

J. R. Chappell  
Hewitt Johnston  
H. A. Day  
Louis Orr

#### PALM BEACH COUNTY MEDICAL SOCIETY:

W. W. George V. M. Johnson

#### PINELLAS COUNTY MEDICAL SOCIETY:

W. M. Davis  
A. J. Wood  
O. O. Feaster  
W. C. McConnell

#### POLK COUNTY MEDICAL SOCIETY:

J. R. Boulware R. L. Cline

#### PUTNAM COUNTY MEDICAL SOCIETY:

E. W. Ford

ST. JOHNS COUNTY MEDICAL SOCIETY:  
G. W. Potter

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY  
MEDICAL SOCIETY:  
H. D. Clark

SEMINOLE COUNTY MEDICAL SOCIETY:  
T. F. McDaniel

VOLUSIA COUNTY MEDICAL SOCIETY:  
Roy Howe H. Z. Silsby

It was moved, seconded and carried that Doctor Roberts be seated as a delegate from Bay County.

It was also moved, seconded and carried that Doctor Vinson be seated as a delegate from Hillsborough County.

As the first order of business the president recognized our delegates to the A. M. A.

*Doctor Mallory:*

Our report has been published in the Journal. All I can say is that both of your delegates attended every one of the sessions at the San Francisco meeting, and also every session of the Chicago special meeting.

We have two recommendations to make for your consideration. The first is that your delegates be chosen a year ahead of time. Our meeting of this association comes so close to the national meeting that it is hard to get the recognition that we should in the House of Delegates. Committee appointments are made some time before the meeting takes place. If the Speaker of the House of Delegates is to recognize you your name must be in there. If the names of our delegates could go in a year earlier they would get far more recognition.

The next recommendation is that your two delegates should be advisory members of the executive committee. Certainly this would make our delegates more capable of handling their work when they attend meetings of the A. M. A.

*Doctor Bryans:*

I have nothing additional to report.

It was moved and seconded that the minutes of the last meeting as published in the June, 1938, issue of the Florida Medical Journal, be adopted. No corrections were made and the minutes were unanimously adopted.

President Spiers called for the nomination of one delegate and one alternate to the House of Delegates of the American Medical Association for two-year terms.

Dr. Meredith Mallory was nominated for reappointment by Dr. Louis Orr. Nomination duly seconded by Doctor Cline. Dr. Homer Pearson was nominated for appointment as delegate to the A. M. A. by Doctor Rowlett. Nomination seconded by Doctor Johnston. It was moved, seconded and carried that the nominations be closed. Doctors Summerlin and Ferguson were appointed tellers. Motion by Dr. Joe. Stewart that the man receiving the highest number of votes be appointed delegate and that the man with the lower number of votes be appointed as alternate. Seconded and carried.

Dr. Meredith Mallory 26. Dr. Homer Pearson 19.

The following resolution was read by Doctor Day of Orlando:

BE IT RESOLVED, That the House of Delegates now in session pass the following resolution:

That henceforth the Florida Medical Association shall have a representative in Tallahassee during the entire session of the Legislature, who is well versed in handling medical legislation, and that the entire burden of legislation not be placed on the future committees;

That it is next to impossible for practicing physicians who live at a distance from Tallahassee to be in close contact with all legislation at all times;

That the duty of the committee on Legislation and Public Policy be to formulate and direct favorable legislation for the public health and to keep our representative in Tallahassee informed as to those Bills which would affect public health adversely.

Upon motion duly made, seconded and carried the above resolution was unanimously adopted.

The following communication was read by Dr. J. L. Summerlin of Gainesville:

INSTRUCTIONS TO DELEGATES FROM  
ALACHUA COUNTY MEDICAL SOCIETY

The following motions were passed at a called meeting of the Alachua County Medical Society on April 26, 1939:

1. That our delegates be instructed to register a complaint with the Florida Medical Association in regard to the inadequacy of the legislative policy of the Florida Medical Association.

2. That the delegates register a complaint as to the inadequate function of the legal department in regard to help furnished us in regard to illegal practitioners.

3. That the Alachua County Medical Society favors and approves the employment of a full time, competent, legislative contact man for the Florida Medical Association, who is familiar with political works. That his salary should be adequate and, if necessary, our dues be raised.

We ask this with a spirit of cooperation and a willingness to take our share of the burden at any time.

J. M. DELL, JR., M. D., *Secretary*

At the suggestion of the president it was voted to refer this communication to the Legislative Committee.

Dr. Arthur H. Weiland of Coral Gables read a proposed lien law and requested that it be referred to the Legislative Committee for whatever action is necessary to bring it before the legislature of the State of Florida.

It was moved, seconded and carried that the proposed Bill be referred to the Legislative Committee.

A resolution was presented by Doctor Hendricks of Broward County for improvement in management of Florida State Hospital commitment routines. Motion by Doctor Walter Jones that this resolution be referred to the Committee on Medical Education and Hospitals, said committee to report its find-



ings at the next meeting of the House of Delegates. Motion seconded. Motion amended by Doctor Chappell that the name of the committee be changed to the Committee on State Controlled Medical Institutions. Amendment accepted by Doctor Jones and motion seconded and carried. Resolution referred to Dr. Harold D. Van Schaick, chairman of the Committee on State Controlled Medical Institutions for consideration and report at the next meeting of House of Delegates.

The following resolution was presented by Doctor L. Y. Dyrenforth of Jacksonville:

**A RESOLUTION SUPPORTING THE CONSTRUCTION OF A NEW BUILDING FOR THE ARMY MEDICAL LIBRARY AND MUSEUM, IN THE CITY OF WASHINGTON, DISTRICT OF COLUMBIA.**

*To the members of the Florida Medical Association, in Convention Assembled, May 1, 2 and 3, 1939, at Daytona Beach, Florida:*

WHEREAS the scope and efficiency of the United States Army Medical Library and Museum are becoming increasingly diminished through lack of proper housing, and for a number of years have taxed and harassed the abilities of officials, and

WHEREAS the continued efficiency of the Army Medical Library and Museum means much to the general and specialized practice of medicine in this and all other States, and

WHEREAS the Army Medical Library, the largest in the world, and the Museum are institutions maintained for the public welfare and health, built to their present status of world renown by the untiring efforts of successive Surgeons General, and

WHEREAS the subject of appropriation for this express purpose has already been passed by the 75th Congress, but no funds provided,

NOW, THEREFORE, BE IT RESOLVED, That the Florida Medical Association place itself on record as strongly recommending that necessary and prompt measures be enacted by the 76th Congress to consummate construction of adequate quarters for these Institutions.

THAT such measures are urgently necessary for the proper maintenance and uninterrupted functioning of these institutions,

THAT a Committee be appointed by the Association's President to follow through this matter until such appropriation is made,

AND THAT a copy of this resolution be forwarded to each member of the Florida delegation in Congress, the President, the Secretary of War, the Director of the Budget and the Surgeon General of the Army.

It was moved, seconded and carried that the above resolution be adopted.

The following recommendation of the Executive Committee was presented by Doctor Osincup, chairman: That the 1940 annual meeting be held in Tampa. Upon motion duly seconded and carried, Tampa was designated as the convention city for 1940.

Doctor Osincup then recommended the granting of a charter to the newly formed Franklin-Gulf County Medical Society. It was moved, seconded and carried that this charter be granted.

## REPORTS OF COMMITTEES

The following report of the Council was read by Doctor Harrison Walker, chairman:

### REPORT OF THE COUNCIL

The first meeting of the Council was held June 30, 1938, at Daytona Beach. For the benefit of the newly appointed councilors an outline of a councilor's duties was given. All councilors were urged to continue with the activities handed down from last year's Council. In connection with the annual medical district meetings, it was recommended that the entertaining society should not solicit funds from its members for entertainment purposes. Printed programs are furnished from the State Association's office and the only expense necessary is in connection with a luncheon or supper. The recommendation, therefore, was to the effect that each person present should pay for his own meal ticket.

The next meeting of the Council was held on October 27 at Gainesville, just preceding the medical district meeting. Some problems confronting the St. Johns County Medical Society were taken up for discussion. No definite action was taken.

At the time of the Pre-Convention Meeting in Jacksonville on January 29, 1939, the Council again met for the purpose of hearing annual reports from the various councilors. These reports were published in the February, 1939 Florida Medical Journal. A schedule of dates for the 1939 annual medical district meetings was approved.

At the request of Dr. N. A. Baltzell, councilor of the second district, a recommendation was approved for the organization of a new county medical society to be known as the Franklin-Gulf County Medical Society. This recommendation was referred to the Executive Committee, requesting that this new medical society be allowed to function until the next meeting of the House of Delegates.

On February 12 the Council again met at St. Augustine, with the members of the St. Johns County Medical Society. The entire afternoon was devoted to a discussion of a problem which had been referred to the Council by that medical society. The question involved was whether a doctor should be taken into the society. After careful deliberation and study of the evidence, the Council advised that the decision was in the hands of the county society.

The six annual medical district meetings held during the past year were, in the opinion of the Council, very constructive. The total attendance was 445 which was about the same as for the previous year. Many of the doctors who attended the district meetings were not privileged to attend the annual meeting of the State Association. The officers of the State Association, the chairman of the Executive Committee and the chairman of the Council attended all of the meetings, with very few exceptions. The round table discussions at these district meetings, lead by the officers of the State Association, in the six districts of the state have proved to be very valuable. This particular activity of the Council is bringing the Association affairs to its members and is a real contribution to the constructive up-building of organized medicine in the state.

The Florida Midland Medical Society disbanded during the year. Dr. W. C. McConnell of St. Petersburg, the president, and Dr. J. W. Alsobrook of Plant City, councilor for that district, encouraged the move. The reasons for the disbanding of this independent medical group were quite logical, their contention being that the Southwest Medical District was almost identical with the territory covered by the Midland Medical Society and that the doctors in that district should give their support to the Association's medical district meeting and not duplicate such efforts by an independent society. This society was organized some twenty-two years ago and the members feel that their purposes have been accomplished, in holding the interest of the doctors of the district, and that now they should turn their support to the district meeting. In the December, 1938,

Florida Medical Journal on page 300, a complete report will be found of the termination of the Florida Midland Medical Society, with some very interesting reading concerning its history. Your Council wishes at this time to recognize the sterling qualities of the doctors of the Southwest Medical District for the action they have taken and their offering of full cooperation to the State Association in developing the medical district.

Elaborate plans are under way for the six meetings in the medical districts this year. Programs are being arranged, which will include a total of twenty-four scientific papers. The essayists, after reading their papers, will have the privilege of turning them in to the editor of the Journal for publication. The original articles presented at the medical district meetings are not only of interest to those who are privileged to hear them, but they are also published in the Journal for the entire membership to read.

As chairman of the Council, I wish to extend my thanks and appreciation to the members of the Council, who have given so generously of their time during the past year. Your councilors have rendered a real service to the Association through faithful and untiring efforts.

Respectfully submitted,

HARRISON A. WALKER, *Chairman*.

On motion duly seconded and carried the above report was adopted.

The Chair then recognized Dr. J. Harris Pierpont of Pensacola, and presented him to the delegates as the oldest past president of the Association and the only doctor to serve more than one term as president.

The following report of the Committee on Scientific Work was presented by Dr. Walter C. Jones, chairman:

#### REPORT OF COMMITTEE ON SCIENTIFIC WORK

Your Committee on Scientific Work found that it had quite a problem when it began the formation of a program for your Association. There are some suggestions we would like to make to the House of Delegates, for your adoption, if it meets with your approval.

First, we had the problem of formulating this year's program from forty-four papers. We have been able to use only seventeen of them. We have arranged them in as near a group that fits the various specialties without any highly specialized paper being used, as it was possible for us to do. We have steered away from highly specialized papers. We felt that the papers which should be presented to the Association were those of a more general interest but with some underlying relationship to the specialist as they happen to fall. This procedure is not by official action but is simply a thought that we would like to bring before you.

As we sat down with some forty-four papers with fifty-word synopses, it was almost impossible to arrive at a satisfactory program for the Association. We tried to place a paper from one or more persons from each of the districts; not knowing the material that was in these papers. Fifty words cannot tell us what is in the paper. I think we could have a much more logical arrangement of the program if we could have minimum synopses of five hundred words, or preferably a copy of the paper before it is placed on the state program. We have the full responsibility and we would therefore like to have a better idea of what the material is before we place it on the program.

I would like to say a word in regard to the Publication Committee. This committee is striving to raise the standard of the Journal as rapidly as possible. They have now a goodly number of papers in reserve and if you have a paper returned to you, don't feel hurt. We are trying to raise the standard of the medical publica-

tions in the State as rapidly as possible. Your committee has ruled against the use of out-of-state papers in the Florida Journal. It is our feeling that this Journal represents the State Association and it should carry out of the State the type of medicine that is being carried on in the State. We do not feel that we are getting a fair break as some of our best papers are published out of the State. After all, the Florida Medical Journal is the one that carries to the outside world the type of medicine that Florida is doing.

Motion by Dr. Ferguson that the above report be adopted. Seconded and carried.

The following report of the Committee on Legislation and Public Policy was read by Doctor Day, chairman:

#### REPORT OF COMMITTEE ON LEGISLATION AND PUBLIC POLICY

We have had our work for the present session of the Legislature well outlined. We are supporting only one Bill for passage of this session of the Legislature, the Basic Science Bill (Bill S-35). At present this Bill has been reported favorably out of the Senate Committee and will be up for passage in a short time. If it passes the Senate it will then be presented to the House as a Senate Bill.

Your chairman has been in constant contact with Tallahassee so far this session and has read all Bills introduced that would affect public health of the State, favorably or unfavorably, and we have so far successfully kept unfavorable legislation from reaching the floor of the House or Senate.

We wish to sincerely thank all of those who have so heartily cooperated with us in our work, and especially our president, Doctor Spiers, who has untiringly worked with us and for us in trying to secure passage of favorable legislation and to keep adverse legislation from being passed.

Respectfully submitted,

HORACE A. DAY, *Chairman*.

On motion, duly seconded and carried, the above report was adopted.

The following report of the Committee on Medical Education and Hospitals was read by Dr. John R. Chappell, chairman:

#### REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Your Committee has devoted its time almost entirely during the past year in an effort to obtain from the ninety-one hospitals and sanitariums in the state, detailed information concerning their medical staffs, their constitutions and by-laws governing the medical staffs and copies of all existing contracts between said hospitals and doctors on the staffs. A letter was mailed to these hospitals and sanitariums in the state requesting this information immediately following the State Convention in Miami.

Up to the present time we have had answers from thirty-three hospitals in the state, a majority of them sending copies of their constitutions and by-laws and listing the members of their medical staffs. We have attempted to go over most of these replies and submit, attached to this report, a list of the hospitals which have replied to our request together with what recommendations we feel necessary to these institutions.

At the State Convention in Miami, a resolution was passed and adopted by the House of Delegates entitled—"The Relation of Physicians and Hospitals," setting down certain rules and regulations which must be adopted by the various hospitals as a condition upon which



members of the Florida Medical Association may continue to serve on the staff of the institution, which institution should be approved annually by this Committee. Immediately following this meeting of the House of Delegates, a meeting of the Executive Committee of the Florida Medical Association was held and it was agreed that any action on this resolution should be held in abeyance until a ruling could be obtained from the Legal Department of the American Medical Association. A copy of this resolution was sent to Doctor Leland of the American Medical Association in Chicago, and Doctor Leland felt that before such a resolution should be put in force, it should be made binding on the members of the Florida Medical Association and that the principles of the resolution should be made a part of the by-laws of the State Association.

This suggestion from Doctor Leland was reported to the Executive Committee in Daytona Beach last June and at the same time the by-laws of the Florida Medical Association were gone over and found to contain such rules as would make this resolution binding on the members of the State Association, similar to the suggestion made by Doctor Leland. The Executive Committee voted at this meeting to hold in abeyance any action enforcing the requirements of this resolution until further notice. Since that time your Committee has not taken any action or made any attempt to try to enforce this resolution. We also felt that because of the existing conditions over the country in general, particularly the attitude of the present administration in Washington regarding organized medicine, it would be inadvisable to try to enforce this resolution.

Your Committee will continue during the ensuing year to obtain from the hospitals who have not replied to our request, copies of their constitutions and by-laws, also lists of members of their medical staffs, and will attempt to draft model constitution and by-laws for those institutions that do not have any, asking the other institutions to conform as nearly as possible to the by-laws which we feel necessary under the resolution as passed at the state meeting in 1938.

From the answers received up to date, it is obvious that a number of hospitals in the state have contracts with pathologists and radiologists. Most of these contracts are oral, there being no written contract in existence. It is also obvious that such contracts are illegal according to the resolution passed at the May meeting in 1938.

Your Committee is in somewhat of a dilemma as to the advisability of forcing or requesting these hospitals to discontinue any such contracts. A discussion of this point by the House of Delegates would be appreciated by your Committee.

Respectfully submitted,

J. R. CHAPPELL, *Chairman.*

#### SUPPLEMENT TO ABOVE REPORT

*Century*—Turberville Hospital: medical staff satisfactory; constitution and by-laws need revising; oral contract with pathologist.

*Chattahoochee*—Florida State Hospital: will not give any information regarding staff, constitution and by-laws, except that it is governed by the Board of Commissioners of State Institutions, composed of the Governor and his cabinet.

*Daytona Beach*—Halifax District Hospital: medical staff satisfactory; constitution and by-laws need revising; contracts denied.

*Ft. Lauderdale*—Broward General Hospital: medical staff satisfactory; no constitution or by-laws; denies contracts.

*Ft. Myers*—Lee Memorial Hospital: medical staff unsatisfactory in that it was not listed; apparently no constitution and by-laws as none were submitted; denies contracts.

*Gainesville*—Alachua County Hospital: medical staff satisfactory; constitution and by-laws satisfactory; contract with radiologist, oral; pathologist, oral. Florida Farm Colony Hospital: Medical staff consists of two doctors (medical superintendent and chief physician).

No constitution and by-laws; denies any existing contracts.

*Jacksonville*—Brewster Hospital (colored): medical staff satisfactory; constitution and by-laws unsatisfactory in their requirements for membership; contracts with pathologist and radiologist. Duval County Hospital: medical staff not given as requested; constitution and by-laws not furnished; contracts with pathologist and house staff. St. Luke's Hospital: no information given regarding medical staff, constitution and by-laws, or contracts. St. Vincent's Hospital: medical staff satisfactory; oral contracts with radiologists, pathologists and anesthetists.

*Key West*—U. S. Marine Hospital: medical staff consists of two medical officers and two interns; no constitution and by-laws except regulations of U. S. Public Health Service; contracts—surgeon and dentists both written but copy of contracts not submitted.

*Lake City*—Veteran's Administration Facility: medical staff satisfactory; no constitution and by-laws; maintained and controlled by the U. S. Government; contracts denied.

*Lake Wales*—Lake Wales Hospital: medical staff satisfactory; constitution and by-laws satisfactory; contracts—none listed.

*Miami*—Dade County Hospital: medical staff satisfactory; constitution and by-laws need revising; contracts with radiologist, pathologist, and tuberculosis clinician. Edgewater Hospital: letter returned unclaimed. James M. Jackson Memorial Hospital: medical staff satisfactory; constitution and by-laws need revision; contract with radiologist-pathologist; house staff on salaries. Miami-Battle Creek Sanitarium: medical staff consists of medical director and two physicians; constitution and by-laws unsatisfactory; contracts with two physicians, apparently residents, and radiologist.

*Miami Beach*—St. Francis Hospital: medical staff satisfactory; constitution and by-laws should be revised; denies contracts.

*Orlando*—Florida Sanitarium and Hospital: medical staff satisfactory except names of courtesy staff should be submitted; constitution and by-laws need revising; contracts denied. Orange General Hospital: medical staff satisfactory; constitution and by-laws satisfactory; existing contracts—pathologist, oral; radiologist, oral.

*Palatka*—Glendale Hospital: medical staff not listed; constitution and by-laws need revising; oral contracts with radiologist and pathologists.

*Panama City*—Lisenby Hospital: staff consists of Dr. A. H. Lisenby; no constitution and by-laws; no contracts.

*Pensacola*—Pensacola Hospital: medical staff satisfactory; constitution and by-laws need revision; oral contract with radiologist.

*Raiford*—Florida State Prison Hospital: medical staff—one physician, one dentist, one eye, ear, nose and throat consultant; constitution and by-laws—none except general statutes of the State of Florida; denies existing contracts.

*St. Augustine*—East Coast Hospital: medical staff satisfactory; no constitution and by-laws; contracts denied. Flagler Hospital: medical staff satisfactory; constitution and by-laws need revising; contracts denied.

*St. Petersburg*—American Legion Hospital for Crippled Children: medical staff consists of one surgeon and two assistants; no constitution and by-laws; denies contracts. Florence Crittenton Home: medical staff satisfactory; constitution and by-laws not obtained; denies contracts. St. Anthony's Hospital: medical staff satisfactory; constitution and by-laws unsatisfactory; contracts denied.

*Sebring*—Dr. Weems' Hospital: medical staff satisfactory; no constitution and by-laws; contracts denied.

*Tampa*—Hillsborough County Tuberculosis Sanitarium: no medical staff, county physician does the work; no constitution and by-laws; denies contracts.

*Union*—Harry-Anna Crippled Children's Home: medical staff consists of four outside physicians and one resident physician; no constitution and by-laws; de-

nies any existing contracts other than oral understanding of employment. Lake County Medical Center: medical staff satisfactory; constitution and by-laws need revision; contracts with radiologists and pathologists; hospital has contract with members of its active staff, who receive 10c per mile pay for services.

Motion to adopt the above report duly seconded and carried.

The following resolution was presented by Dr. H. Mason Smith of Tampa:

#### RESOLUTION

WHEREAS, there is a movement sponsored by several bills before the Legislature to create a branch hospital for the insane in the peninsular part of the state; and

WHEREAS, one bill designates a site offered free of charge by the City of Avon Park, which site is on a lake front and presents beautiful topography, good agricultural soil and has the highest altitude of any part of the state; and

WHEREAS, the other sites are not so desirable for an institution of this kind; and

WHEREAS, there has been existing a profound need for an institution of this character in the populous part of the peninsula for years; and

WHEREAS, such an institution would serve the poor people who are so unfortunate as to have mental illness in their families, to a great advantage, by its proximity to them; and

WHEREAS, in the opinion of the doctors of this state, a smaller unit is more conducive to the scientific care of the insane, is better also for administrative purposes; therefore be it

RESOLVED, that this body of delegates memorialize the Legislature to create such an institution on the site proffered by the City of Avon Park, which is so located as to serve best the greatest territory of any site so offered. It is especially desirous that the Legislature create a branch in South Florida and this place, so far as geography is concerned, is the best that is available.

Motion by Doctor Vinson that the above resolution be adopted. Motion seconded and carried.

The following report of the Committee on Public Relations was read by Dr. J. Ralston Wells in the absence of the chairman, Dr. Roy J. Holmes:

#### REPORT OF PUBLIC RELATIONS COMMITTEE

Your Committee on Public Relations has been somewhat handicapped this year in having as its chairman one so far removed from the principal point of activity, namely Station WRUF at Gainesville. Your chairman accepted his appointment with the belief that the work being accomplished in such a commendable fashion through Station WRUF could be broadened and extended in order to cover every part of the State. It appeared to us as extremely desirable that other stations, patterned after the work being done at Gainesville, could be set up at Miami and possibly Jacksonville and Tampa. We may report at this point that the continuation of the programs at Gainesville has been possible only through the untiring efforts of our President and the interest of members of this committee in that particular section of the State.

As an experiment, reputable and ethical sponsors agreed to finance the cost of fifteen minutes each week over Station WQAM at Miami. Believing that the average radio listener would be more interested in in-

terviews and dramatizations of intense human interest than in the usual health lecture, it was decided to dramatize the programs as much as possible.

Our first set-back was encountered in the matter of material. While it seemed from the listed dramatizations and interviews that the American Medical Association could furnish an abundance of material, closer examination revealed the fact that most of the material furnished by the American Medical Association was obsolete, and so written as not to rebound to the credit of this organization.

Secondly, we were handicapped in presenting even those dramatizations which could be used by the fact that we had no funds with which to employ professional talent when needed.

Notwithstanding these impediments, your committee has been instrumental in presenting 24 fifteen-minute broadcasts over Station WQAM at Miami, and has managed to supply Station WRUF at Gainesville with appropriate weekly presentations over our entire allotted time. Your committee has also answered numerous communications from the laity and has acquired a great deal of literature on the question of socialized medicine, which can be used as broadcasting material, if it should ever become necessary or if the Association should think it wise to go into this problem publicly. Your committee has not felt that it was prudent to do so during the past year.

Respectfully submitted,

Roy J. HOLMES, *Chairman*.

It was moved, seconded and carried that the above report be adopted.

The following report of the Committee on Necrology was read by the chairman, Dr. G. Walter Potter:

#### REPORT OF COMMITTEE ON NECROLOGY

During the past year, our Association lost, by death, the members whose names are listed below:

Andrew P. Albaugh, Tarpon Springs.  
Omer R. Alexander, Winter Haven.  
John F. Binkley, West Palm Beach.  
George O. Davis, Madison.  
Raymond C. Denison, Lake Worth.  
Thomas B. Echard, St. Petersburg.  
Henry Gatrell, Fairfield.  
Max Ghertler, Miami.  
A. Comer Knight, Jacksonville.  
W. E. Mitchell, Bushnell.  
G. E. Osgood, St. Petersburg.  
Butler H. Sanchez, Plant City.  
Richard G. Tietze, Winter Haven.  
John B. Tower, Homestead.

When possible, obituaries have appeared in the Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we, at this time, stand in a moment of silence, in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,

GEORGE W. POTTER, *Chairman*.

On motion seconded and carried the report of the Committee on Necrology was adopted.

The following report of the Committee on Medical Postgraduate Course was read by the chairman, Dr. T. Z. Cason:



#### REPORT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE

The total paid attendance at the 1938 Short Course, held at Daytona Beach, was 132. This was a slightly higher number than at any previous session. The increase in attendance is still more evident when the relatively small number of men from Volusia County is considered.

The financial report for the 1938 Short Course shows total receipts of \$660.00 and total expenditures of \$655.87. The balance in the treasury on February 1, 1938, was \$367.09, and on January 1, 1939, was \$371.12. This does not include the amount of money expended by the State Board of Health, which was approximately the same as ours. The Graduate Short Course this year will again be given in cooperation with the State Board of Health.

The program of the 1939 Short Course will be published in the May issue of the Florida Medical Journal, together with further notes on the faculty. This year we have a different pediatrician from last year, but not a new one to his many listeners. There will be a new obstetrician and a new lecturer on surgery. There will be no evening symposia, as the committee felt the attendance did not warrant the expenditure.

An innovation which is still in the process of formation is that of having one highly specialized course run through the entire week. This year it was decided to offer a course on diseases of the chest. The course is practically assured if finances can be guaranteed. If the special course is conducted this year and the committee feels it is worthwhile, such a course will be attempted each year.

The attendance at the courses is still far below what it should be. This is particularly true in view of the fact that graduate education is occupying increasingly more time of the medical profession.

The committee would like to have suggestions as to general improvements and the subject for the special course next year, should such a course be given.

Respectfully submitted,

TURNER Z. CASON, *Chairman*.

The following report of the Committee on Cancer Control was read for the chairman, Doctor Hoffman:

#### REPORT OF COMMITTEE ON CANCER CONTROL

Two meetings were held during the year, the first at Daytona Beach, June 30, 1938, at which time the committee decided to confine its activities to educational matters to be brought to the Medical Societies and the general public. In the latter connection, your committee acted as the Executive Committee for the State division of the Women's Field Army of the Society for the Control of Cancer. This organization has done a wonderful job and surely should be commended on its activities in bringing cancer education to the general public.

Your committee, through the various County Medical Societies throughout the State, has endeavored to keep before the medical men the question of early diagnosis and treatment.

Your committee has served as a clearing house for personal letters sent to the National Office of the American Society for the Control of Cancer from residents of Florida. These letters have usually been sent back to the local group of doctors for answer. On occasion, where the local doctor requested, these letters were answered by the chairman.

We would recommend that cancer control committees be designated in each County Medical Society to cooperate with the District State Committeeman.

We would also recommend that cancer clinics be established in key centers about the State. These clinics would serve to aid the doctors in diagnosis and also in treatment. These clinics should conform to the stand-

ards as outlined by the American College of Surgeons. Advantage can be taken by a recognized clinic of the use of radium from the National Institute of Cancer for indigent cases.

Respectfully submitted,

JAMES M. HOFFMAN, *Chairman*.

On motion duly seconded and carried the above report was adopted.

A report of the Committee on Medical Economics was read by the chairman, Dr. J. C. Vinson. It was moved and seconded that this report be adopted. After open discussion, Dr. T. M. McDuffee withdrew his second to the motion as follows: "I would like to withdraw my second to the above motion, as I feel that this report should be referred to the proper committee for study and be reported back to the House of Delegates tomorrow." Doctor Vinson then withdrew the motion. It was moved by Doctor Hendricks and seconded by Doctor Jones that the plan of the chairman of the Committee on Medical Economics be mimeographed today and that a copy be furnished each member of the House of Delegates for study; and that this matter come up for further discussion at the second meeting of the House of Delegates. Voted and carried.

The following report of the Committee on Inter-Relationship was read by the chairman, Dr. W. M. Rowlett:

#### REPORT OF THE INTER-RELATIONSHIP COMMITTEE

1938, being an off-legislative year, your Committee has had very little to accomplish in legislative matters. However, since the opening of the legislature last month we have contacted our allied organizations relative to any proposed bills to be introduced in the present legislature and in this way have prevented conflicts with each other's programs and we stand united in mutual assistance in legislative matters.

We wish to reiterate the importance of inviting the presidents of the various allied associations to be our guests at the annual meeting of the State Association. Such courtesy would result in a wholesome friendship and a better understanding.

Respectfully submitted,

W. M. ROWLETT, *Chairman*.

On motion duly seconded and carried the above report of the Inter-Relationship Committee was adopted.

The report of the Committee on Tuberculosis and Public Health was not presented due to the absence of the chairman, Dr. M. Jay Flipse.

The following report of the Committee on State Controlled Medical Institutions was read by the chairman, Dr. H. D. Van Schaick:

## REPORT OF COMMITTEE ON STATE CONTROLLED MEDICAL INSTITUTIONS

During the past year your President delegated to the Committee on State Controlled Medical Institutions the duty of developing the idea of Mental Hygiene in the State of Florida.

There was considerable correspondence and several conferences and the Committee met in Jacksonville, and later attended a meeting of the Research Committee of the Mentally Unfit.

The results of this activity has been crystallized in the thought that there should be formed a Mental Hygiene Society of Florida under the control of the Florida Medical Association and participated in by the lay organizations. Dr. Ralph Stevens finally wrote the Constitution, a copy of which is submitted.

It is recommended that the officials of the State Medical Society give this serious consideration and, if they concur in the action of the Committee, to institute such procedures as are necessary for the promulgation of this idea. On the other hand, after receiving the approval of the Society, the same Committee would be glad to put the idea into effect.

We have enjoyed serving on this Committee.

Respectfully submitted,

HAROLD D. VAN SCHAIK, *Chairman*.

It was moved, seconded and carried that the above report be received.

Motion by Doctor Ferguson that a Mental Hygiene Society be organized. Seconded and carried.

The following report of the Committee on Maternal Welfare was read by the chairman, Dr. Ferdinand Richards, and included the report of the Committee on Child Health:

## REPORT OF COMMITTEE ON MATERNAL WELFARE AND CHILD HEALTH

The work done by the Committee, in collaboration with the Bureau of Maternal and Child Health of the State Board of Health, during the past year has been very encouraging. The state-wide survey of maternal deaths instituted last year by Dr. Homer L. Pearson, former Chairman of the Committee, has continued. Much valuable information has been obtained from this survey.

Thanks go to Dr. Frank V. Chappell, Director of the Maternal and Child Health Bureau of the State Board of Health, and his field workers, and Dr. Edward M. L'Engle, Director of the Bureau of Vital Statistics, for cooperating wholeheartedly with the Committee in conducting this survey. Many thanks are also due the medical profession for furnishing the information necessary to make this survey a success. However, in many instances the information recorded on the death certificate by the attending physician is not complete enough to form the basis for definite conclusions. Therefore, the Committee respectfully urges physicians to give more consideration and thought as to the cause of death before filling out the certificate; this alone, will help lower the reported death rate. Out of a total of 234 maternal deaths only one physician in the Association refused to cooperate with the Committee in this study.

The death rate in Florida continues slightly higher in the colored race than in the white. The total number of live births in Florida for 1936 was 28,084; the number of maternal deaths was 216, giving a rate of 7.7. In 1937 the total number of live births was 29,488 with 196 maternal deaths, giving a rate of 6.6. In 1938 there were 31,095 live births and 234 maternal deaths giving a rate of 7.5. The mortality rate for the United States for 1937 was 4.88; in Florida it was 6.6. The maternal death rate for the United States in 1938 is not yet

available; therefore, the Committee is unable to compare Florida's maternal death rate with the national rate, until these figures are made available. Furthermore, it is impossible to account at present for this rise and fall in the maternal death rate but the Committee believes that this survey will bring to light the reason for these changes in the maternal death rate and also will assist materially in finding the cause of this continued high maternal mortality. Therefore, every effort should be put forth to continue the present program.

Seventeen counties in the State have full time County Health Departments and it is in these counties that the maternal conferences and clinics are carried on with the help of money received from the Children's Bureau of the United States Department of Labor. These clinics meet monthly, semi-monthly, or weekly, according to the number of indigent patients in the County. The eligibility of these patients for free service is determined by social service workers, but if no worker is available, the family physician may issue the certification. In most of these cases, delivery will be by midwives who are asked to bring the patients for a regular monthly check-up or more often if the physician in charge wishes. In cases where it is possible, these clinics are conducted by the local practicing physicians who are members in good standing of their respective Medical Societies. The physicians are paid at the rate of \$3.50 an hour for their work in these clinics. At least sixty physicians are participating in this work. A movement is on foot by the Children's Bureau to allow a consultation fee of \$10.00 when complications arise and the services of a specialist is necessary.

The high rate of infant mortality which exists in Florida, as well as in other southern States, is due to the death of children born prematurely. With better prenatal care and better correlation of all facilities available this high mortality can be gradually reduced. The main factors in the mortality in older age groups are ignorance and the poor economic status which prevail in a large portion of our population. So many children receive inadequate food which predisposes to malnutrition with all its sequelae. When these two fundamental conditions are changed for the better, naturally there will be a reduction in the morbidity and mortality in the higher age groups of children.

With the proper, efficient functioning of all health units in the several counties, much will be accomplished in the prevention of disability. The medical personnel of these units must perform its duties diligently and these duties must not be delegated to nurses for their performance.

In conclusion, the Committee's recommendations are: first, continuation of this survey; second, that each physician who signs the death certificate exercise more care and thought in listing the cause of death.

Respectfully submitted,

FERDINAND RICHARDS, *Chairman*,  
*Committee on Maternal Welfare*.

L. W. HOLLOWAY, *Chairman*,  
*Committee on Child Health*.

On motion duly seconded and carried the above joint report was adopted.

The following report of the Advisory Committee to the Woman's Auxiliary was read by the chairman, Dr. Gordon H. Ira:

## REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

In October, 1938, the Advisory Board met with the officers of the Woman's Auxiliary and formulated plans for the coming year. The following charges were sent to each Auxiliary by Dr. W. Henry Spiers:

1. Continue to publicize as widely as possible the necessity for periodic examinations of domestic servants, as well as periodic health examinations for all.



2. Hold yourself in readiness to cooperate 100 per cent with the chairman of the legislative committee; and see that your organization becomes informed about socialized medicine.

3. Cooperate with the Tuberculosis Association, particularly in the Christmas Seal sale.

4. Cooperate with the Southern Jane Todd Crawford Memorial scholarship fund.

5. Hold regional auxiliary meetings at the same time and place of the state medical meetings as nearly as possible.

6. Hold a bigger and better second annual Health Institute day.

7. Secure A. M. A. broadcasts over your local station and urge the schools of your county to permit the pupils to listen and make use of them in their science classes.

8. Continue diligently to distribute the magazine Hygeia.

9. Cooperate with the Cancer Field Army.

10. Prepare an interesting exhibit for the state medical meetings.

11. Secure the health education program, 1938-39, of the National Auxiliary, from Mrs. V. E. Holcombe, 1635 Quarrier Street, Charleston, West Virginia.

The auxiliaries have cooperated particularly well with reference to the legislative program this year. The Health Institute programs, where they were put on, were very successful.

It is very pleasing to note that a national recognition was bestowed upon one of the county auxiliaries by the American Medical Association this year. They offered three \$50.00 prizes for the largest number of Hygeia distributed in proportion to the members, and ten prizes for the next best achievements. The little statue displayed here is in recognition of the number distributed by the Duval County Woman's Auxiliary. It is also pleasing to note that five of the prizes were distributed to counties in southern states, of which section, one of our auxiliary members is southern chairman.

The Woman's Field Army for the Control of Cancer afforded an excellent opportunity for the auxiliaries to cooperate with the cancer program. The American Medical Association broadcasts were secured over many local stations, and were favorably received.

It is the opinion of the Committee that the Woman's Auxiliary is a very valuable asset to the Association and could even be more so if it were our desire to use them.

Very respectfully submitted,

GORDON H. IRA, *Chairman.*

On motion duly seconded and carried the report of the Woman's Advisory Committee was adopted.

The following report of the Committee of Representatives to the Industrial Council was read by the chairman, Dr. Arthur H. Weiland:

#### REPORT OF REPRESENTATIVES TO THE INDUSTRIAL COUNCIL

It is the desire of the Committee of Representatives to the Industrial Council to call attention to certain phases of the practice of industrial medicine and surgery in Florida.

In the approximate time of four years since the Florida Compensation Act became a law, many irregularities have periodically appeared in the operation of this law as affecting the physicians of Florida. As is often the case with any new procedure, the time element is a very important factor in the facility with which such procedure may be carried out. Such has also been the case with this Compensation Act as it pertains to the members of the Florida Medical Association.

During the past two years some agitation was started

to bring about the establishment of a state-wide fee schedule. In June of 1938, a joint meeting of the Executive Committee and the Industrial Relations Committee was held at the Osceola Hotel at Daytona Beach, the main objective being to discuss the adoption of a proposed state-wide fee schedule.

At this meeting, various representatives of the Florida Medical Association, together with representatives of the Insurance Claim-Men's Association, as well as the Deputy Industrial Commissioner were heard. After hearing these discussions, a meeting of the Representatives to the Industrial Council was held and it was felt that a state-wide fee schedule could not be satisfactorily applied to all localities in the State of Florida at this time. The opinion was expressed, however, that if desired, the various component societies might make up their own schedule of fees to use in their particular localities.

Your committee is informed that there are certain contemplated changes in the Compensation Act as regards the limit of expenditures of funds and the care of injured workmen, and that these limits, both surgical and non-surgical, are shortly to be raised. This should, in a large measure, operate to the mutual advantage of the injured employee, and to the physician in charge.

Your committee is still cognizant of the fact that undue influence may be exerted by representatives of state insurance organizations in the selection of attending physicians. It is felt that the essential requisite is that the physician selected should be qualified to act in the capacity in which he is called and that he should be acceptable to the injured party, else a necessary feeling of confidence between the patient and physician is sacrificed.

There have still been reported charges of lifting, that is, unwarranted transfer of patients from one physician to another or from one hospital to another without sufficient cause. Likewise, your committee has been given reports of over-treatment of patients to pad medical bills. Fortunately, both of these evils are felt to be on the decline.

This committee is of the opinion that in cases of dispute or points in question between the physician and the patient or physician and insurance representative or between any of the parties in any given case of compensation practice, that the Industrial Commissioner or Deputy Commissioner should be acquainted with the full facts in the case. In the majority of such cases, a solution satisfactory to all parties may be thus reached.

Respectfully submitted,

ARTHUR H. WEILAND, *Chairman.*

It was moved, seconded and carried that the above report be adopted.

The following report of the Committee on Venereal Disease Control was read by the chairman, Dr. E. T. Sellers:

#### REPORT OF COMMITTEE ON VENEREAL DISEASE CONTROL

The first meeting of the Venereal Disease Control Committee was held April 5, 1937, at the Vinoy Park Hotel, St. Petersburg. The committee realized at that time that the eradication of venereal diseases would be a very slow process and one that would necessarily require a definite plan to be carried forward over a period of years. With this in mind, the committee outlined a program in detail and recommended it to the Association.

The committee has held meetings from time to time at which the attendance has been unusually good. The chairman has had full cooperation from all the members on the committee. Each member has done especially good work in his community and on the whole satisfactory progress has been made. There are a few recommendations, however, thought to be the least difficult to execute, on which there has been very little progress made.

The Division of Venereal Disease Control was instituted July 1938 from funds provided by the U. S. Public Health Service. The personnel of this division is composed of a director and assistants under the direction of the State Health Officer. The State Director and his assistants have been very active in instituting control measures for the eradication of venereal diseases. This especially applies to publicity measures. The following is an outline of the committee's original recommendations and a comment on what has been accomplished.

1. **Methods of Reporting Venereal Diseases:** The committee recommended that a specific blank with a post-free, self-addressed envelope be mailed to physicians for the reporting of venereal diseases. This is a very simple matter and would be a great help in the reporting of venereal diseases. We see no reason why it should not be put into effect immediately.

2. **Epidemiological Investigations:** To secure effective epidemiological investigations, it is necessary to inform physicians as to their importance. This is being done through the State Director of the Venereal Disease Control Work and also by the members of the Venereal Disease Control Committee of the State Association.

3. **The Private Physician:** As to the treatment of syphilis, a blank has been printed giving detailed treatment of the disease in most of its manifestations and stages. This is being mailed to the various physicians of the state by the State Director of Venereal Disease Control Work. The treatment for gonorrhea has been greatly improved due to the recent advances in chemotherapy. We feel that the treatment is on a very much more logical basis.

4. **Clinics:** A few more clinics over the state have been established for the treatment of the indigent venereal patients and plans are under way for more. The drugs for the treatment of syphilis are being furnished to county and city health officers for indigent patients.

5. **Laboratory Facilities:** We feel that the laboratory facilities of the State Health Department have been improved; however, facilities for the examinations are too distantly scattered over the State to be of a great deal of value to many doctors in the diagnosis and treatment of venereal disease.

6. **A Health Department Responsibility:** As far as we have been able to determine, there has been nothing done on the part of the State Health Department to discourage the treatment of venereal diseases by druggists and others who are not licensed to practice medicine. The laws of the State are specific in regard to venereal diseases and we feel that the Health Department could do a great deal more in the discouragement of the treatment of these diseases by those who are not licensed to do so.

7. **Education:** There has been a great deal done in informing the public in regard to venereal diseases. In fact, our greatest progress has been made in this direction. The members of this committee have been especially active in their respective communities in presenting programs for the education of the public. However, ignorance and fear still remain our most difficult problems. The need for authentic material in the way of pamphlets, posters, and books suitable for lay readers is being met by the American Social Hygiene Association and its affiliated groups. Unfortunately this volunteer health association is not well organized in Florida, having only a few local councils and not even one paid worker.

A well organized Council of Social Hygiene in each of the larger counties and district councils to serve groups of less populous counties would give an enormous impetus to our work. Such Councils, made up of community leaders under the guidance of qualified physicians, dedicated to the constant spreading of scientifically correct information on venereal diseases, would soon make great progress in venereal disease control, similar to that made by Tuberculosis Associations in the control of tuberculosis.

The State Health Department has available several moving picture films on venereal diseases which are loaned to interested groups. These films have been used

by one local Council of Social Hygiene as a nucleus around which to build a general educational campaign. In this instance, the greatest emphasis has been placed on high school students and young business women. However, the program should be enlarged to reach all groups in the community, regardless of age and occupation.

8. **Prophylaxis:** The keynote of prophylaxis is the education of the public and this is being done.

Respectfully submitted,

ELIJAH T. SELLERS, *Chairman.*

It was moved, seconded and carried that the above report be adopted.

The report of the General Advisory Board of Past Presidents was then given by Dr. Henry E. Palmer, chairman, as follows:

#### REPORT OF ADVISORY BOARD OF PAST PRESIDENTS

This is a new General Advisory Board of Past Presidents and it has not functioned very thoroughly but, as chairman, I have met with the president on several occasions at his request and at various points in the State. We ex-presidents are very much gratified at the formation of this special Board. It makes us feel that we are still useful and have a place in the Association. I assure you that we are all willing at any time to serve the Association to the best of our ability.

It was moved, seconded and carried that this report be adopted.

#### NEW BUSINESS

A letter from R. C. Woodard, M. D., Superintendent of the Jackson Memorial Hospital, Miami, to Doctor Spiers, relating to a suit against this hospital, was read by Doctor Chappell. After open discussion, Doctor Chappell made a motion, which was seconded and carried that the Florida Medical Association offer the Dade County Medical Society a vote of confidence and moral support.

Motion that the vote of confidence and moral support be extended also to include the Hillsborough County Medical Society. Seconded and carried.

Recommendation by the Duval County Medical Society that Dr. Henry Bacon of Jacksonville, a member of this organization for thirty years, be admitted into Honorary Membership in the Association, was read and unanimously adopted.

A telegram from the Pharmaceutical Association, extending heartiest greetings and wishes for a successful convention was read by the secretary, Dr. Shaler Richardson.

Announcement was made of meeting places for various committees.

There being no further business to come before the session, on motion, duly seconded and carried, the meeting adjourned.



## FIRST GENERAL SESSION

The Sixty-sixth annual meeting of the Florida Medical Association was called to order at 1:30 p. m. Monday, May 1, in the Assembly Room of the Hotel Princess Issena, Daytona Beach, by President W. Henry Spiers.

Invocation by The Right Rev. Monsignor Wm. J. Mullally.

The Hon. F. V. B. Couch, Mayor of Daytona Beach, gave the address of welcome.

Doctor Maximilian Stern, President of the Volusia County Medical Society, also delivered an address of welcome.

The following reports of delegates to the Convention of the Medical Association of Georgia was made by Doctor Holden:

### REPORT OF DELEGATES TO MEDICAL ASSOCIATION OF GEORGIA

Dr. Gerry R. Holden:

As usual your delegates were welcomed in Georgia with heartiest cordiality. Nothing was undone to assist us in our comfort and our pleasure, and our Georgia brothers showed themselves to be true brothers during our visit in Atlanta.

The delegates who follow me will speak more of the social events and possibly about the scientific program. I have attended a number of meetings of the Medical Association of Georgia, both as delegate and as just plain visitor, and it occurred to me that it might be well this afternoon to tell you something of their Association, especially to tell you something of the differences that exist between their Association and ours and, if I may be permitted to vaguely hint, some lessons which we might learn from the Medical Association of Georgia.

It is rather interesting that two states side by side should develop their Associations along different lines. There are a number of differences existing between their Association and ours. It begins in the first place in the very names of the Associations. Our Association is the Florida Medical Association. Their Association is the Medical Association of Georgia. There is, however, in existence, I understand, a Georgia Medical Association. I have been looking around the room for some of our Georgia fraternal delegates to ask them to tell us exactly what their Georgia Medical Association is, but I do not see any of them. Are there any of the Georgia Delegates here?

(Answer from the floor: The Georgia Medical Association is made up of colored doctors).

The name of our sister Association is the Medical Association of Georgia. It might be well to bear that in mind when we go to Georgia.

This meeting in Atlanta was the ninetieth annual session of the Medical Association of Georgia. This is our sixty-sixth annual meeting. They antedate us quite a bit.

We compared the population of Georgia and Florida with the number of doctors in each state, and found that in Georgia there is one doctor to a little more than each one thousand of population. In Florida we have one doctor to approximately each eight hundred of population. Organized medicine is fairly well developed in both States. In Georgia sixty per cent of the doctors are eli-

gible men in their Association. In Florida we have sixty-two per cent—hardly enough to crow over.

At the time of their meeting in Atlanta last week they had 1,555 members according to the statement of Doctor Shanks from the floor, while our membership according to the last report is 1,293. So you see there are about 250 odd doctors more in their Association than we have.

There are many differences regarding the way the meetings are held. Our meeting begins, including the house of delegates, on Monday morning and lasts until Wednesday noon, two and one-half days. In Georgia they begin on Monday at 2:00 o'clock and adjourn Friday at noon, giving them four whole days of meeting time. Naturally with more time at their disposal they are able not only to have more lengthy scientific programs, but they have also more time at their disposal to devote to business meetings and the House of Delegates.

At the last meeting in Atlanta, thirty-two of their members read scientific papers at the scientific program, while this year we have scheduled about seventeen men. I understand that many good papers had to be refused this year because we did not have time to put them on.

I would like to call your attention to the way the meeting of the House of Delegates is held in Georgia. They begin at 2:00 o'clock in the afternoon of the first day. There is no smoker that night. The House of Delegates gets down to work. They adjourn about six o'clock. At 6:30 there is a meeting of the Council. About 8:00 o'clock the House of Delegates reconvenes and works as long as necessary, often they do not adjourn until late at night. Naturally with this time at their disposal they are able to handle more easily business than we are in our Association with limited time in which our House of Delegates has to work.

As to the reports: I have been to a number of Georgia meetings and the reports submitted to their House of Delegates are as a rule most excellent. In the State of Georgia many activities are reported at the House of Delegates. To my mind the outstanding report at the last meeting was that of Dr. Charles W. Roberts of Atlanta. He read a rather long paper, but not too long for the meat that it contained. Doctor Roberts analyzed and described the activities of the House of Delegates at the last meeting of the American Medical Association in a wonderful and exceedingly valuable manner.

One thing they do in Georgia appeals to me. In the House of Delegates as soon as their meeting convenes, the President appoints three committees which are called reference committees. The chairman of each of these committees is a past president of the Medical Association of Georgia and the majority of the members of those committees I think are past presidents of the Medical Association of Georgia. Now, when any reports of committees are submitted to the House of Delegates, or reports submitted in other ways, instead of being discussed on the floor they are referred to one or another of these reference committees and then that evening these reference committees meet to consider these reports. Any member of the Association who wants to fight over these reports goes into that little room with the committee and they fight it out there. They settle many things right in those committees and when the committees report back to the House of Delegates there is no occasion for long arguments or discussions that would naturally take place if they did not have that procedure. I don't mean that they don't have arguments on the floor. I have heard some very heated arguments on the floor, but certainly they are minimized. This method of handling House of Delegates reports is the same procedure that is used in Congress, in State Legislatures, and in many other bodies. It may not be proper for a delegate to a neighboring state to make suggestions; however, I cannot but feel that if our House of Delegates was handled along these lines its business would be expedited.

It has been a great privilege for us to go to Georgia. Homer Pearson and I have been up there a number of times and we have decided to go back every year whether appointed as delegates or not.

Dr. Homer Pearson:

In the absence of Doctor Page, I might say, that he was very faithful in his attendance at the various sessions of the House of Delegates and the scientific programs. I tried to take care of the fraternal side of it and did the best I could at the "tea parties," etc.

I will not take up any more time other than to say that I enjoyed my visit to Atlanta and hope that I will be able to go again some time.

Doctor Charles Andrews, delegate from the Medical Association of Georgia, was introduced.

Doctor Andrews:

I want to apologize or offer my sympathies that Georgia has sent you a rather scrappy delegate when they have so many illustrious gentlemen who might have come. But it seems as if the pestilence and plague and perhaps the ravages of a lucrative practice knocked them out one by one.

Doctor Anderson came down for the meeting yesterday but as he had to go back he asked me to express his regret that he is unable to attend.

Doctor Davidson, who came down last year, was due to be here but at the last minute some infectious disease developed and he could not get away.

Yesterday Doctor Fort wired the Georgia delegates to the Florida Association that he was unable to come due to ill health.

It is always a pleasure to be in Florida. I love it perhaps almost as much as Georgia. I bring you the greetings of the Medical Association of Georgia and best wishes for your continued good work and success.

There being no new business to come before the session at this time, upon motion duly seconded and carried the meeting adjourned.

### FIRST SCIENTIFIC ASSEMBLY

The Scientific Assembly convened at 2:30 p. m. Monday, May 1, in the Assembly Room of the Hotel Princess Issena, with Dr. Herbert E. White presiding.

The following papers were read and discussed:

1. "Puerperal Infections Versus the General Practitioner," Dr. William C. Roberts, Panama City.

2. "Five Hundred Consecutive Operative Gynecological Cases," Dr. Ferdinand Richards, Jacksonville.

3. "Treatment of Automobile Accidents," Dr. E. B. Hardee, Vero Beach.

4. "Some Observations on the Treatment of Pellagra," Dr. J. Frank Wilson, Jacksonville.

5. "Eugenic Sterilization," Dr. A. T. Cobb, Gainesville.

6. "An Evaluation of the More Common Serodiagnostic Tests of Syphilis," Dr. James N. Patterson, Jacksonville.

### SECOND SCIENTIFIC ASSEMBLY

The Second Scientific Assembly was held Tuesday, May 2, 9:00 a. m., Dr. Walter C. Jones presiding.

The following papers were read and discussed:

7. "The Thyroid and Adrenal Glands as Factors in the Control of Fever, Heat Regulation, and Climate," Dr. N. L. Spengler, Tampa.

8. "Hyperthyroidism — Medical Phases," (lantern slides), Dr. Webster Merritt, Jacksonville.

9. "Hyperthyroidism—Surgical Aspects," (lantern slides), Dr. W. Duncan Owens, Miami Beach.

### SECOND GENERAL SESSION

The Second General Session of the Florida Medical Association was called to order at 11 a. m., Tuesday, May 2, 1939, in the Assembly Room of the Hotel Princess Issena.

President Spiers in the Chair.

The following telegrams were read by the secretary, Dr. Shaler Richardson:

From Dr. N. A. Baltzell: "Ill with infected hand. Regret inability to be with you all today. Best wishes for a successful meeting."

From Dr. J. C. Davis: "Unavoidably detained last minute. Regrets. Best wishes for banner meeting."

From C. P. Loran, Secretary-Manager Southern Medical Association: "Greetings and all good wishes. We hope you are having a most successful annual meeting."

### REPORTS OF OFFICERS

The following report of the Secretary-Treasurer-Editor, Shaler Richardson, and Managing Director, Stewart Thompson, was read by Dr. Shaler Richardson:

REPORT OF SECRETARY-TREASURER, EDITOR OF THE JOURNAL, DR. SHALER RICHARDSON; AND MANAGING DIRECTOR, DR. STEWART THOMPSON

*To the President and Members of the Florida Medical Association in session at Daytona Beach, Florida:*

The steady and substantial growth of our State Medical Association is most encouraging. For many years the Association's program has been enlarged with increasing interest and activity along many new lines. We may well be proud of the past year's achievements. The membership last year totaled 1,293, as compared to 1,244 for the previous year. This represents a net increase of 49. This total of 1,293 members was published in the Medical Directory by component societies, and for that reason will not be reproduced here. The Dade County Medical Society headed the list with 282



members; the Duval County Society had 169; and the Hillsborough County Society, 104.

The attendance at last year's annual convention was 762. The attendance at the six annual medical district meetings was 445; and the attendance at the Pre-Convention Meeting was 59, making a total attendance at the eight official, annual meetings of 1,266. The annual conventions of the Association have been so well attended the last few years that the question of adequate hotel space is a serious one. It may be that the time is ripe to confine the Association's annual conventions to cities where large hotels are available and follow the present policy of holding the six annual medical district meetings in other cities. The attendance at the Association dinner last year was 430. An exceptionally large dining room is, therefore, necessary to take care of the members and guests who wish to attend that function. During the last two or three years, exhibit spaces were sold out before the date of the annual convention and many desirable applicants were turned away. The Association's annual dinner and technical exhibits are important units in the annual convention and hotel facilities should, therefore, be adequate.

Special efforts have been made to increase the interest and worthwhileness of your Journal. Fifty-six scientific papers were published during the year as well as abstracts of 40 papers published by members in other medical journals. The circulation of your Journal is steadily increasing. A total of 18,393 Journals were mailed from your home office during the past year.

The second edition of the Florida Medical Directory was published the early part of this year. We believe it contains information of value to members and other interested groups. To date, 2,720 Directories have been mailed. Scarcely a day passes without orders being received for copies of this Directory. Advertising in both the Journal and the Medical Directory has been confined to firms whose products are Council-passed. There has been a definite increase in the number of advertisements during the past year, as compared to the previous year.

Additional office space at 128 East Forsyth Street was authorized by the Executive Committee. Your office force was previously working under a tremendous handicap, owing to very crowded conditions. Your Journal is mailed from our office by the use of an addressograph. The mailing list is, therefore, kept accurately and the work done at a considerable saving. During the year 21,113 Journals and Directories were mailed with the aid of the addressograph. The mimeograph machine also requires space for its operation. A total of 24,569 letters and forms were produced on the mimeograph. Mail going out through your office was: 340 packages, 13,724 letters, in addition to the Journal and Directories. Incoming mail was: 4,474 letters, 1,027 Journals, 176 packages and 67 books.

Your employees assisted many of the standing committees and the Council, as well as Association officers. Commendation received from chairmen of various committees for services rendered was highly appreciated. The office is maintained for the use of members. Assistance will be given to any of the regular committees on request. The detail work in connection with the six medical district meetings, including the printing of programs, notification letters, etc., was handled through your office, under the direction of Dr. Harrison A. Walker, chairman of the Council.

News releases on all of the Association's official meetings were sent to newspapers throughout the state and you have undoubtedly observed the results obtained so far along this line.

#### FINANCES

Financial statements in full will be published in the Journal, following this report. Receipts during the fiscal year were \$22,332.72; disbursements, \$19,399.09; leaving a balance for the year of income over disbursements of \$2,933.63. However, \$2,000 of this is to be held available for the Committee on Legislation and Public Policy if needed. The net balance of \$933.63 may, therefore, be considered as a net gain for the

year. For the benefit of those members who do not study the financial statements, the Association's income was derived as follows: dues and entrance fees, \$13,507.50; earnings from advertising in the Journal and Medical Directory, \$5,230.69; subscriptions to the Journal and sale of Medical Directories, \$1,414.80; interest on savings and investment, \$529.48; rentals on technical exhibits, \$1,643.75; miscellaneous, \$6.50; total \$22,332.72.

Expenditures during the year were: general fund, \$9,069.60; printing of Journal, Directory, etc., \$7,729.70; percentage to entertaining society, \$714.50 and convention expense, \$754.27 from exhibit fund; expenses of standing committees, \$885.41; office equipment, \$175.20; library, \$34.50; books, \$23.70; federal tax, \$12.15; total, \$19,399.09.

Advertising income the past year was \$5,230.69, as compared to \$4,616.57 for the previous year, making an increase of \$614.12 from this source of revenue. This substantial increase we feel has been due to special contacts made through the office with prospective advertisers.

With the increasing interest in organized medicine, the membership reached its peak last year. A larger membership, of course, increases the revenue from dues. Dr. Edward Jelks, immediate past president, suggested a change in the By-Laws, requiring an entrance fee for new and reinstated members. Since January 1, \$370.00 has been collected as entrance fees. This not only is an additional source of income, but also overcomes a difficulty experienced in previous years as to the status of a member. On December 31 a member is dropped, whose dues for that year were not paid. To be reinstated he pays an entrance fee of \$10.00, even though he may have been out of organized medicine for a number of years. The paying of several years' back dues is not required by this change in the By-laws. A reinstated member pays only \$10.00 entrance fee and \$10.00 current dues, regardless of the number of years he may have been out of organized medicine.

We are happy to report that many doctors going through Jacksonville have called at the Association's home office. Representatives from advertising and exhibit firms are visiting the office more frequently. It is maintained for you. Every opportunity to serve you you will be welcomed.

The books and records of the Association are open to our members and we will be glad to answer inquiries of any nature. The books have been audited by Ford and Colley and a certification thereof is incorporated in the statements which follow.

Respectfully submitted,

SHALER RICHARDSON, M. D.  
STEWART THOMPSON, D. P. H.

FORD & COLLEY

CERTIFIED PUBLIC ACCOUNTANTS

Jacksonville, Florida, April 29, 1939.

Dr. Shaler Richardson,  
Treasurer,  
Florida Medical Association, Inc.  
Jacksonville, Florida.

Dear Sir:

We have examined the attached statements of Cash Receipts and Disbursements of Florida Medical Association, Incorporated, for the period begun April 20, 1938, and ended April 20, 1939. These statements have been prepared by Dr. S. G. Thompson, Managing Director of the Association and the Florida Medical Journal, and Miss Naomi Anderson, bookkeeper, and correctly reflect the cash transactions for the period stated as shown by the books of account. The books are in excellent condition.

We have checked the additions of the cash record, and have compared the disbursements as entered therein with the cancelled checks returned by the bank. We have checked the recorded collections to the bank deposits as shown by the bank's statements, and have obtained the written confirmation of the bank as to the

balance at the close of the period. We have obtained the written confirmations of the banks as to the savings accounts. We have checked the general ledger postings, and have verified general ledger additions.

As we do not have access to the records of the various County Societies for the purpose of checking the remittances of dues, attention is directed to Exhibit "D" which gives details regarding this matter.

Income from Journal advertising was verified substantially by comparison with a detailed statement of contracts with advertisers furnished by you.

The ten United States bonds, par value \$1,000.00 each, were verified by us with The Atlantic National Bank of Jacksonville, Florida.

Yours very truly,

FORD & COLLEY

### CONSOLIDATED CASH STATEMENT

April 21, 1938 through April 20, 1939

<i>Receipts</i>	
Cash in Bank, April 21, 1938	\$ 21,822.30
Dues and Entry Fees Collected (Exhibit "D")	\$13,507.50
Earnings from Advertising (Exhibit "E")	5,230.69
Subscription and Misc. Sale of Journal and Directory	1,414.80
Interest on Savings and Investment	529.48
Miscellaneous Income	6.50
Earnings—Technical Exhibits (Exhibit "C")	1,643.75
Total Cash to be Accounted for	\$44,155.02

<i>Disbursements</i>	
General Fund Expenses (Exhibit "A")	\$ 9,069.60
Journal and Directory Expenses (Exhibit "B")	7,729.70
Technical Exhibit Expenses (Exhibit "C")	\$754.27
To Entertaining Society	714.50
Committee Expenses (Exhibit "A")	885.41
Furniture, Fixtures and Equipment	175.20
Library	34.50
Books by C. W. Warner	23.76
Federal Tax	12.15
Balance in Bank, April 20, 1939	\$24,755.93

### EXHIBIT "A"

#### CASH STATEMENT—GENERAL FUND

April 21, 1938 through April 20, 1939

<i>Receipts</i>	
Cash as per last audit	\$ 21,822.30
Back dues collected (Exhibit "D")	\$ 2,997.50
Current dues collected (Exhibit "D")	10,140.00
Entrance Fees collected (Exhibit "D")	370.00
Interest on Savings and Investment	529.48
Miscellaneous Income	6.50
From Exhibit Fund	174.98
Total Cash to be Accounted for	\$ 36,040.76

<i>Disbursements</i>	
Postage and Supplies	\$ 498.81
Telephone and Telegraph	141.89
Salaries	6,720.00
Traveling Expense	551.05
Delegates (2) Transp. to San Francisco	289.95
Legal Counsel	100.00
Office Rent	510.00
Towel Service	15.00
Auditing Books	12.50
Electrotypes	13.79
Messenger Service	7.95
Express	1.40
Bank Exchange	3.86
Custody of Bonds (1937 & 1938)	20.00
Photostats	19.60
News Service	59.00
Treasurer's Bond	18.75
Repair Furniture, Clean & Repair Typewriters, Adding Machine, etc.	49.44
Moving Office Equipment	10.50
Incidental	26.11
Committees:	
Council	222.54
Legislative	548.40
Executive	49.39
Public Relations	26.54
Postgraduate Course	28.96
Cancer Control	1.33
Publication	.77
Tuberculosis & Public Health	5.93
Medical Economics	.30
Hospital	.25
Scientific Work	1.00
Furniture, Fixtures & Equipment	175.20
Library	34.50
Books by C. W. Warner	23.76
Federal Tax	12.15
To Jnl. & Directory Fund (Cost above Income)	1,084.21
CASH BALANCE	\$24,755.93

### EXHIBIT "B"

#### CASH STATEMENT— JOURNAL AND DIRECTORY FUND

April 21, 1938, through April 20, 1939

<i>Receipts</i>	
Cash as per last audit	\$ 0.00
Earnings from Advertising (Exhibit "E")	\$5,230.69
Subscrip. & Misc. Sale	\$957.80
Collected Acct. Rec.	457.00
From General Fund	1,084.21
To be Accounted for	\$7,729.70
<i>Disbursements</i>	
Postage and Supplies	\$ 410.89
Printing and Plates	4,576.03
Telephone and Telegraph	78.72
Salaries	2,580.00
Dray and Express	18.76
Auditing Books	12.50
Photostats	2.05
Messenger Service	5.80
Bond of Treasurer	18.75
Addressograph Service & Repair	24.20
Copyright, Directory	2.00
CASH BALANCE	\$ 0.00



EXHIBIT "D"

Dues and Entrance Fees Collected April 21, 1938, through April 20, 1939

Name of Society	Total Members	Number Paid	No. in Arrears	1939 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	28	21	7	\$ 200.00	\$ 120.00	\$ 10.00
Bay	11	11	0	100.00	20.00	
Brevard	11	7	4	60.00		
Broward	33	33	0	320.00		10.00
Columbia	19	14	5	130.00	50.00	20.00
Dade	288	178	110	1,770.00	950.00	80.00
DeSoto-Hardee-Highlands-Charlotte-Glades	19	19	0	180.00	40.00	
Duval	169	160	9	1,580.00	327.50	40.00
Escambia	44	32	12	300.00	110.00	10.00
Franklin-Gulf	6	6	0	50.00	30.00	
Hillsborough	106	75	31	730.00	230.00	40.00
Individuals	2	0	2			
Jackson	14	12	2	110.00	40.00	
Lake	18	13	5	120.00	30.00	
Lee	14	11	3	100.00	20.00	10.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	37	27	10	260.00	220.00	10.00
Madison	3	2	1	10.00	10.00	10.00
Manatee	13	13	0	120.00	10.00	10.00
Marion	20	20	0	180.00	10.00	10.00
Monroe	4	4	0	30.00	30.00	
Orange	76	66	10	650.00	90.00	10.00
Palm Beach	58	50	8	490.00	200.00	20.00
Pasco-Hernando-Citrus	15	14	1	130.00	30.00	
Pinellas	88	88	0	860.00	30.00	10.00
Polk	61	61	0	600.00	230.00	30.00
Putnam	10	9	1	80.00	20.00	
St. Johns	10	10	0	90.00	10.00	
St. Lucie-Okeechobee-Indian River-Martin	16	16	0	150.00	10.00	10.00
Sarasota	17	10	7	90.00	40.00	
Seminole	12	12	0	110.00		
Sumter	3	2	1	20.00		
Taylor	8	6	2	50.00	20.00	
Volusia	41	37	4	360.00	70.00	30.00
Walton-Okaloosa	6	6	0	50.00		
Washington-Holmes	8	7	1	60.00		
TOTALS	1,288	1,052	236	\$10,140.00	\$2,997.50	\$370.00

2,997.50 Back dues Collected

13,137.50 Total dues Collected

370.00 Entrance Fees Collected

\$13,507.50 DUES & ENTRANCE FEES

EXHIBIT "C"

CASH STATEMENT—EXHIBIT FUND

April 21, 1938, through April 20, 1939

Receipts

Cash as per last audit	\$ 0.00
Earnings from Technical Exhibits	1,643.75
Total Cash to be Accounted for	\$1,643.75

Disbursements

Convention Expense:	
Postage and Supplies	\$ 1.28
Telephone and Telegraph	31.53
Floor Plan and Electrottype	31.97
Sign Painting, etc.	126.00
Printing	7.50
Programs (1938 & 1939)	142.38
Badges	27.67
Employees' Transportation	183.63
Proceedings' Reporter	79.35
News Service	83.61
Incidental	39.35
	\$754.27
To Entertaining Society:	
Dade County Med. Soc.	68.00
Volusia County Med. Soc.	646.50
	714.50
To General Fund	174.98
	1,643.75
CASH BALANCE	\$ 0.00

EXHIBIT "E"

EARNINGS FROM ADVERTISING

April 21, 1938, through April 20, 1939

May, 1938	\$ 340.72
June	447.78
July	319.02
August	399.16
September	352.22
October	424.27
November	318.40
December	398.44
January, 1939	272.00
February	636.66
March	403.46
April	538.44
	\$4,850.57
Refund, A. M. A.	380.12
TOTAL	\$5,230.69

## ASSETS AND LIABILITIES

April 20, 1939

<i>Assets</i>	
Cash in Bank.....	\$11,811.24
General Fund—Accounts Receivable.....	2,360.00
Books by C. W. Warner.....	23.76
Entertaining Society.....	57.00
Furniture, Fixtures & Equipment, less Depr.....	845.82
Library.....	571.55
Stationery Inventory.....	161.11
Savings: Atlantic National Bank.....	4,225.21
Barnett National Bank.....	8,719.48
Investment (Treasury Bonds).....	10,178.13
	<hr/>
	\$38,953.30
<i>Liabilities</i>	
Capital Account.....	\$38,837.60
Journal Deferred Income.....	115.70
	<hr/>
	\$38,953.30

## EMERGENCY FUND—(Memorandum No. 1)

(Taken from Treasurer's Financial Statement)

January 1, 1937, to April 20, 1938

<i>Debit</i>	
1937 Statement, Apr. Jnl. page 519, Exhibit "D".....	\$8,740.00 (874 members @ \$2.50) \$2,185.00
1938 Statement, June Jnl. page 661, Exhibit "D".....	\$9,400.00 (940 members @ \$2.50) 2,350.00
1937 Back Dues, June 1938 Jnl. page 661, Exhibit "D".....	\$2,785.00 (less \$15.00, 1936)
	\$2,770.00 (277 members @ \$2.50) 692.50 \$5,227.50
Less Amount Reserved for Working Budget and Expended (1½ yr.).....	<hr/> 2,250.00
BALANCE.....	<hr/> \$2,977.50

*Credit*

April, 1937, Journal, page 518, Exhibit "A"

## Committee Expense:

Postgraduate Course.....	\$ 2.00
Legislative.....	228.30
Public Relations.....	66.21
Hospital.....	2.00
Maternal Welfare.....	11.17
Medical Economics.....	1.50
Scientific Work.....	46.23

June, 1938, Journal, page 659, Exhibit "A"

## Committee Expense:

Postgraduate Course.....	15.00
Legislative.....	1,208.18
Executive.....	16.00
Public Relations.....	31.34
Veneral Disease.....	.48
Council.....	156.26
Scientific Work.....	22.61
Misc. Com. Expense.....	4.35
	<hr/> 1,811.63

BALANCE NOW AVAILABLE.....\$1,165.87

(The above form, setting forth the balance in Emergency Fund, together with expenditures as indicated, approved and adopted and the treasurer of the Association authorized to publish memorandum in his Annual Report, by action of the Executive Committee, June 30, 1938).

## EMERGENCY FUND—(Memorandum No. 2)

(Taken from Treasurer's Financial Statement)

April 21, 1938, through April 20, 1939

<i>Debit</i>	
Balance on hand, April 21, 1938.....	\$1,165.87
(Memorandum No. 1)	
Back Dues Collected (Exhibit "D").....	\$2,997.50 (less \$7.50, 1935)
	\$2,990.00 (299 members @ \$2.50) \$ 747.50
Current dues collected (Exhibit "D").....	\$10,140.00 (1014 members @ \$2.50) 2,535.00 3,282.50
To be Accounted for.....	<hr/> \$4,448.37
Less Amount Reserved for Working Budget and Expended.....	<hr/> 1,500.00
BALANCE.....	<hr/> \$2,948.37

*Credit*

## Committee Expense:

Council.....	\$222.54
Legislative.....	548.40
Executive.....	49.39
Public Relations.....	26.54
Postgraduate Course.....	28.96
Cancer Control.....	1.33
Publication.....	.77
Tuberculosis & Public Health.....	5.93
Medical Economics.....	.30
Hospital.....	.25
Scientific Work.....	1.00
	<hr/> 885.41

BALANCE NOW AVAILABLE.....\$2,062.96

(The above form, setting forth the balance in Emergency Fund, together with expenditures as indicated, approved and adopted and the treasurer of the Association authorized to publish memorandum in his Annual Report, by action of the Executive Committee, June 30, 1938).

It was moved, seconded and carried that the joint report of the Secretary-Treasurer and the Managing Director be adopted.

The report of the Executive Committee was read by the chairman, Doctor Osincup, as follows:

## REPORT OF EXECUTIVE COMMITTEE

The first meeting of the Executive Committee was held in Miami, May 11, in conjunction with the Association's Committee on Medical Education and Hospitals, the chairman of the Council, the Committee on Industrial Relations and the officers of the Association. At this meeting Mr. Wendell C. Heaton represented the Industrial Commission. After hearing Mr. Heaton and a number of the doctors present, the consensus of opinion was to the effect that there should be a state-wide standard set for industrial insurance fees. By motion, the group recommended the adoption of a standard fee for industrial surgery and that the standard fee list be transmitted to the various county medical societies for approval or rejection.

The next meeting of the Committee was held June 30 at Daytona Beach. A working budget for the Association's office was presented in typewritten form and after due consideration and study, was adopted. An accounting of the emergency fund which became effective January 1, 1937, was presented in typewritten form, showing a balance of \$1,165.87, covering the period from January 1, 1937, to April 20, 1938. Your Committee approved the method of handling the emergency fund, which is printed in full with the financial statements of the Association's treasurer. A portion of the emergency fund is being used in connection with a full time service



in your home office, as recommended by your Committee to the House of Delegates two years ago. There is a balance from the emergency fund of about \$2,500.00 each two years for necessary expenses of the Committee on Legislation and Public Policy.

A communication from Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association, dated June 3, 1938, was read by the secretary. After referring to the By-Laws of the Association, it was the consensus of opinion that the matter suggested in Doctor Leland's resolution was already covered in our own By-Laws. Action was, therefore, taken to instruct the chairman of our Committee on Medical Education and Hospitals to write to the medical staffs of all hospitals in Florida, submitting a copy of Chapter IX of our By-Laws and a modified copy of the resolution presented at the House of Delegates in Miami and published in the June, 1938, Journal. The question of enforcing the requirements stated in the resolution on hospitals, published in June, was left in abeyance.

Your Committee again met on September 14, 1938, at Ponte Vedra. In accordance with the provision of the By-Laws, Dr. Herbert L. Bryans, delegate to the A. M. A. House of Delegates at San Francisco, read his and Dr. Meredith Mallory's report. The report was received and published in the October, 1938, Journal. A request was received from the DeSoto-Hardee-Highlands County Medical Society to change its name to the DeSoto - Hardee - Highlands - Charlotte-Glades County Medical Society. Your Committee granted this change and the secretary of that society was notified. Doctor Richardson, the secretary of the Association, advised the committee that, owing to unduly crowded conditions in the Association's home office, it was expedient that larger quarters be secured. Additional room was available in the Florida Theatre Building at a rental of \$60.00 a month. The secretary was authorized to make available extra space at a total rental not to exceed \$60.00 a month. Heretofore the Association's home office consisted of one room. With the present equipment of filing stacks, supply cabinets, addressograph, embossing machine, mimeograph, etc., and the addressing and mailing of 1,300 Medical Journals each month and 3,000 Medical Directories each year, your Committee realized that additional space was absolutely necessary.

The next meeting of your Committee was held January 29, 1939, in Jacksonville. Invitations for the 1940 annual convention of the State Association were received from Hillsborough, Duval and Orange County Medical Societies. Since an annual convention has not been held in Tampa since 1928, your Committee recommended that the 1940 annual convention be held at Tampa. A schedule of the program for the annual meeting at Daytona Beach was presented and adopted. The schedule as adopted has been followed in the printed programs given out at this meeting. The Marion County Medical Society recommended for Honorary Membership Dr. Edwin Carlton Hanson. The Pinellas County Medical Society recommended for Honorary Membership Dr. Frank E. Kauffman. Both recommendations were unanimously passed. The understanding of the Association with the Farm Security Administration, as outlined in a letter dated January 20, 1939, was approved. The Association's secretary was instructed to mail a letter to the secretary of each county medical society concerning names of members being used in connection with insurance corporations. This action was taken as a suggestion for the protection of our members.

The next meeting of your committee was held February 19, 1939, at Orlando. The Association's Committee on Legislation and Public Policy held a joint meeting with the Executive Committee and later, met separately. At the joint meeting the question of proper medical legislation was discussed at length. On recommendation of the Committee on Legislation and Public Policy, the Executive Committee authorized the employment of an attorney on a retainer fee of \$500.00 for legal services during the legislative session, ref-

erence Basic Science Bill, and legal services representing the Florida Medical Association in any other matters coming before the legislature, in which the Association may be interested. The following action was also taken by the Executive Committee:

That the treasurer, Dr. Shaler Richardson, be authorized to accept donations from members of the Association, or friends, to be deposited in a National bank for expenses of the Committee on Legislation and Public Policy.

That the said treasurer is authorized to disburse, from monies received through such donations, to the Chairman of the Association's Committee on Legislation and Public Policy, funds as needed for the Committee's expenses.

The Association's treasurer, Dr. Shaler Richardson, is also authorized to turn over to the Chairman of the Association's Committee on Legislation and Public Policy for their expenses from the Emergency Fund, as needed, an amount not to exceed \$2,500; that any items charged on the Association's books as expenses of the Committee on Legislation and Public Policy shall be considered as part of the \$2,500 authorized.

It is suggested that no open discussion from the floor take place concerning the legislative program at this general session. If the members present feel it necessary to discuss medical legislation, it is urged that we go into executive session for that purpose and that the remarks or discussion during the executive session shall be stricken from the record and not be published in the Journal.

A recommendation from the Council was approved, granting the formation of a new county medical society to be known as the Franklin-Gulf County Medical Society and this new society was authorized to function until official action was taken by the House of Delegates.

A recommendation from the Duval County Medical Society for Honorary Membership of Dr. Lester W. Cunningham was approved August 12, 1938.

The official dates for this annual convention were set as May 1, 2, and 3, on October 22, 1938.

Your Committee has been very active during the year, attending meetings and answering communications relative to Association affairs. A great many questions of minor importance were settled by this Committee since the last annual convention of the Association. In this report we have endeavored to outline all important matters that were considered during the year.

Respectfully submitted,

GILBERT S. OSINCUP, *Chairman.*

Motion to adopt the Executive Committee's report as read, unanimously carried.

Doctor Spiers relinquished the Chair to the first vice president, Doctor Arthur Weiland:

Doctor Weiland:

You have all heard and are familiar, I am sure, with the growth of our Florida Medical Association. Few of us, however, realize the amount of time and effort that must be expended by that person who directs the affairs of and is the nominal head of our organization. During the past year our president has traveled over the State giving of his counsel and wisdom to the various component medical societies, and I am sure that he has enriched himself in that experience.

It now gives me pleasure to present the President of the Florida Medical Association, who will deliver his annual address.

The Presidential Address read by Doctor Spiers. (See page 603).

There being no further business to come before the session, on motion duly seconded and carried, the meeting adjourned.

## THIRD SCIENTIFIC ASSEMBLY

The Third Scientific Assembly was held Tuesday, May 2, at 2:00 p. m., Dr. Walter C. Jones presiding.

The following papers were read and discussed:

10. "Atrophic Rhinitis and Otosclerosis," (lantern slides), Dr. S. B. Forbes, Tampa.

11. "The Importance of Case Records Relative to the Cancer Problem," (lantern slides), Dr. R. L. Elliston, Ft. Lauderdale.

12. "Pediatrics Fifty Years Ago and Today," Dr. William W. McKibben, Miami.

13. "Management of Injuries to the Ureter," (lantern slides and motion pictures), Dr. Robert B. McIver, Jacksonville.

14. "Treatment of Hip Fractures by Internal Fixation," (motion pictures), Dr. Arthur H. Weiland and Dr. Charles R. Burbacher, Coral Gables.

## SECOND MEETING OF THE HOUSE OF DELEGATES

The second meeting of the House of Delegates convened at 5:00 p. m., May 2, 1939, in the Inn Dining Room, Hotel Princess Issena, Daytona Beach. President Spiers presided.

The following delegates answered roll call:

## DELEGATES

ALACHUA COUNTY MEDICAL SOCIETY:

J. L. Summerlin

BREVARD COUNTY MEDICAL SOCIETY:

T. C. Kenaston

BROWARD COUNTY MEDICAL SOCIETY:

E. M. Hendricks

COLUMBIA COUNTY MEDICAL SOCIETY:

T. H. Bates

DADE COUNTY MEDICAL SOCIETY:

W. C. Jones

A. H. Weiland

M. M. Coplan

Homer Pearson

C. E. Dunaway

H. A. Walker

K. Phillips

DESOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES COUNTY MEDICAL SOCIETY:

H. V. Weems

DUVAL COUNTY MEDICAL SOCIETY:

R. B. McIver

L. Y. Dyrenforth

J. B. Black

E. T. Sellers

T. E. Buckman

G. H. Ira

ESCAMBLA COUNTY MEDICAL SOCIETY:

L. C. Fisher

J. S. Turberville

FRANKLIN-GULF COUNTY MEDICAL SOCIETY:

Chapman Dykes

HILLSBOROUGH COUNTY MEDICAL SOCIETY:

J. C. Vinson

J. W. Alsobrook

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY:

J. C. Robertson

B. A. Wilkinson

MARION COUNTY MEDICAL SOCIETY:

R. D. Ferguson

ORANGE COUNTY MEDICAL SOCIETY:

Hewitt Johnston

H. A. Day

Louis Orr

R. D. Thompson

PALM BEACH COUNTY MEDICAL SOCIETY:

V. M. Johnson

F. K. Herpel

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY:

W. H. Walters

PINELLAS COUNTY MEDICAL SOCIETY:

W. M. Davis

A. J. Wood

W. C. McConnell

POLK COUNTY MEDICAL SOCIETY:

R. L. Cline

G. H. Carefoot

ST. JOHNS COUNTY MEDICAL SOCIETY:

H. E. White

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN

COUNTY MEDICAL SOCIETY:

H. D. Clark

SEMINOLE COUNTY MEDICAL SOCIETY:

T. F. McDaniel

Dr. Palmer was asked to give the report of the General Advisory Board of Past Presidents.

Dr. Palmer: There was nothing that came before us from yesterday's House of Delegates meeting that was of especial interest.

The resolution for improvement in the management of The Florida State Hospital commitment routines was referred to Dr. H. D. Van Schaick, chairman of the Committee on State Controlled Medical Institutions at yesterday's meeting of this body to be reported on at this time.

Doctor Van Schaick:

The members of the Committee here are Dr. R. E. Stevens, Dr. R. D. Thompson and myself. We have considered this resolution and reached the following conclusions:

1. The commitment of patients to the institution at Chattahoochee is a definite legal procedure which is laid down by the laws of the State of Florida.

2. The laws of the State of Florida would necessarily have to be changed before such a plan can be put in force.

3. The Attorney General is at the present time re-writing laws with which this Committee is not familiar at this time.

4. We feel that the ideal solution would be the adoption of the plan advocated by Dr. Ralph Greene for many years—that is, the establishment of an admitting institution in the central part of the State of approximately two hundred beds, where these suspects can be admitted and studied. Many of these patients would then be able to return to their homes without the stigma of having been sent to the State Insane Asylum.

Therefore, it is the recommendation of this Committee that this resolution be referred back to the Committee for further study.

Motion by Doctor Buckman that the recommendation to refer this back to the Committee on State Controlled Medical Institutions be adopted. Seconded and unanimously carried.

Dr. Vinson reported that the plans for the establishment of a contact bureau of the Florida Medical Association, had been mimeographed and given to each member according to instructions at the first meeting of the House of Delegates. General discussion.



Motion by Doctor Day that this plan be referred back to the Economics Committee for further discussion. Seconded by Doctor Sellers. Suggested amendment to Doctor Day's motion, that this plan be referred to the Economics, Executive, and Public Relations Committees. Amendment accepted by Doctors Day and Sellers. Voted and unanimously carried.

The following resolution was read by Dr. R. D. Ferguson:

#### RESOLUTION

RESOLVED, that any lay organization desiring to form a health program in any form in any county in Florida, shall seek and obtain the approval of the involved county medical society before any member of said medical society may serve on such program.

Resolution by Dr. Ferguson seconded by Dr. Cline, voted and unanimously adopted.

Motion by Dr. H. V. Weems that this body go on record as favoring the establishment of a hospital for the insane somewhere near the central or southern part of the State of Florida. Motion seconded by Dr. Alsobrook.

Amendment by Dr. Ferguson that a copy of this recommendation be sent to the proper legislative committees in Tallahassee. Second amendment by Dr. Copeland that a copy of this motion be sent to the press of the State.

Motion restated by Dr. H. V. Weems to include both amendments: "I move that this body go on record as favoring the establishment of a Branch of the State Institution for the Insane at some location in central or southern Florida, and that a copy of this resolution be sent to the press of the State and that copies be sent to the proper legislative committees at Tallahassee."

Motion seconded by Dr. Alsobrook. Unanimously adopted.

There being no further business to come before the House of Delegates, on motion duly seconded and carried, the meeting adjourned.

#### FOURTH SCIENTIFIC ASSEMBLY

The Fourth Scientific Assembly was held Wednesday, May 3, at 9:00 a. m., Dr. Herbert E. White presiding.

The following papers were read and discussed:

15. "Acute Intestinal Obstruction: Diagnosis and Physiologic Treatment," (lantern slides), Dr. Hugh West, DeLand.

16. "Acute Appendicitis," Dr. Lloyd J. Netto, West Palm Beach.

17. "Gastric and Duodenal Surgery," (lantern slides), Dr. Ralph A. Gowdy, Miami Beach.

#### THIRD GENERAL SESSION

The General Session of the Florida Medical Association reconvened at 11:00 a. m., Wednesday, May 3, 1939, in the Assembly Room of the Hotel Princess Isseña.

President Spiers in the Chair. Meeting called to order.

The guest speaker, Dr. Joseph E. J. King, Director of Neurosurgery at Bellevue Hospital, Lenox Hill Hospital, New York Polyclinic Hospital and the Hospital for the Ruptured and Crippled, New York City, was introduced by Dr. Spiers.

Address, "Brain Abscess," by Dr. Joseph E. J. King.\*

Dr. Spiers:

We are indeed very grateful to Doctor King for coming down here and presenting such a wonderful paper as this. I think we have all enjoyed it very much. I know I have.

There was no unfinished business to come before the meeting.

The following resolution was read by Dr. H. A. Day, Chairman of the Committee on Legislation and Public Policy:

#### RESOLUTION

WHEREAS, there has been introduced in the legislature of Florida a bill commonly known and referred to as "Basic Science Act" and

WHEREAS, the Florida Medical Association deems it advisable and for the best interests of the people of Florida that such proposed bill be enacted into law, now therefore

BE IT RESOLVED BY THE FLORIDA MEDICAL ASSOCIATION, IN GENERAL SESSION DULY ASSEMBLED:

Sec. 1: That the Association does hereby respectfully recommend to the legislature of the State of Florida that such assembly favorably consider the proposed "Basic Science Bill;"

Sec. 2: That certified copies of this resolution be forwarded to the chairman of the Public Health Committee of the State Senate and to the chairman of the Public Health Committee of the House of Representatives; to the President of the Senate and to the Speaker of the House of Representatives.

Done and ordered in open meeting by the unanimous vote of the Association on this, the 3d day of May, A. D. 1939.

Upon motion duly seconded and carried the above resolution favoring the passage by the Legislature of the Basic Science Bill was adopted.

\*To be published in July, 1939, Journal.

The following resolution opposing the proposed House Bills 14 and 392 was read by Dr. H. A. Day:

#### RESOLUTION

WHEREAS, there have been introduced in the House of Representatives of the State of Florida two proposed bills, numbers 14 and 392 respectively, said House Bill number 14 proposing to redefine certain medical terms and including the prescribing of narcotics; and said House Bill number 392 relating to the redefining of the practice of naturopathy, and

WHEREAS, the Florida Medical Association is opposed to the enactment into law of said proposed bills, now therefore

BE IT RESOLVED BY THE FLORIDA MEDICAL ASSOCIATION, IN GENERAL SESSION DULY ASSEMBLED:

Sec. 1: That the Association does hereby oppose the enactment into law of House Bills numbers 14 and 392 and respectfully asks the members of the legislature of the State of Florida to oppose the enactment thereof;

Sec. 2: That certified copies of this resolution be forwarded to the chairman of the Public Health Committee of the State Senate and to the chairman of the Public Health Committee of the House of Representatives; to the President of the Senate and to the Speaker of the House of Representatives.

Done and ordered in open meeting by the unanimous vote of the Association on this, the 3d day of May, A. D. 1939.

Motion made, seconded and unanimously carried that this resolution be adopted.

The following resolution endorsing the program of service to the blind was presented by Dr. Hewitt Johnston:

WHEREAS, Florida is now paying aid to over 2,000 needy blind persons and,

WHEREAS, it would appear that approximately 20 per cent of these can have vision restored by proper medical treatment and,

WHEREAS, approximately 25 per cent might become self-supporting with proper training and guidance, Therefore be it

RESOLVED, that the Florida Medical Society goes on record as endorsing a program of services for the blind including medical services for the restoration or improvement of vision and that a copy of this resolution be forwarded to Mr. C. C. Codrington, Commissioner State Welfare Board, Jacksonville, Florida.

It was moved, seconded and carried that the above resolution be adopted.

#### ELECTION OF OFFICERS

The following tellers appointed by Doctor Spiers: Dr. L. J. Netto, Dr. F. K. Herpel.

Doctor J. S. Turberville of Century nominated as president-elect by Dr. F. K. Herpel.

Nomination seconded by Doctors Lischkoff, Bates, and Palmer.

Motion to close nomination and declare Dr. Turberville unanimously elected. Seconded and carried. So ordered.

Doctor Turberville escorted to the rostrum.

Dr. Turberville:

Mr. President, Members of the Association:

Of course it is needless for me to say that I appreciate the honor you have conferred upon me. I have very little to say, and this will be my hope: that I will not be a disappointment. I thank you very much.

Dr. J. Ralston Wells, Daytona Beach, nominated for first vice president by Dr. Melver.

Nomination seconded by Doctor Holden, who moved that a unanimous vote be cast for Doctor Wells. So ordered.

Dr. T. H. Bates of Lake City nominated for second vice president by Dr. Van Schaick.

Seconded by Doctor Harkness with motion to close nomination. Unanimous vote for Doctor Bates.

Dr. Joseph W. Taylor, Tampa, nominated for third vice president by Doctor Osincup; seconded by Dr. Joe Stewart.

Motion made, seconded and carried that the secretary cast a unanimous ballot for Doctor Taylor. So ordered.

Dr. Gerry R. Holden nominated Dr. Shaler Richardson of Jacksonville, as secretary-treasurer and editor of the Journal of the Association.

Motion to close nominations seconded and carried. Doctor Richardson declared unanimously elected.

Dr. Spiers:

I want to tell you that it has been a pleasure to serve you as President this past year. The hardest part of it has been presiding over the various meetings here. I found out that I did not know anything about parliamentary law after all. I consider this honor you have conferred upon me, that I am just winding up now, as great as any doctor in Florida could have, and coming from my own—men in my own element—I really consider it a greater honor than to be elected Governor of Florida.

Dr. Leigh F. Robinson escorted to the Chair as new President by Dr. G. R. Holden and Dr. John S. McEwan:

Dr. Robinson:

It does not make much difference what you think you are going to say. At times like this you don't know what to say. I do feel deeply grateful for this honor and I promise, in assuming the duties of this office, to do my very best to merit to some extent your confidence.

I feel very humble when I think of the high standards set by our past presidents; and somewhat bewildered when I think of the great responsibilities that face organized medicine. Fortunately, with the various committees and a perfect central management we have an ideal setup to handle the many problems that come before the Association.



Speaking of committees: I have made as few changes as feasible for the coming year. I have contacted either by letter or in person practically all of the committee members and in nearly every instance they have assured me of fine interest and cooperation. Naturally these assurances are inspiring and will stimulate me to do my very best.

Presentation of Past President's button to Doctor W. Henry Spiers by Dr. Palmer:

Henry, you have made us a good President. You have given of your time and your money and your strength, and I think that it has been one of the best years of the Association. You have spared neither time nor labor. You have covered the State not once but several times. And I want to assure you that the members of this Association appreciate your integrity, your faithfulness and your good work, and it is now with great pleasure that I present this button as a token of our appreciation, and I want to welcome you to the membership of the ex-presidents.

Dr. Spiers: "Thank you, Dr. Palmer."

Dr. Walter C. Jones:

Mr. President, I would like to move you, Sir, that the Association go on record as extending our thanks and appreciation for the cooperation of the Volusia County Medical Society and the wonderful entertainment we have received, and the various privileges that have been extended by the City of Daytona Beach.

Motion seconded and unanimously carried.

Announcement of committee meetings.

There being no further business to come before the meeting, on motion duly seconded and carried, the Sixty-sixth Annual Meeting of the Florida Medical Association adjourned sine die.

## REGISTRATION

The total registration during the Sixty-sixth Annual Meeting of the Florida Medical Association, held in Daytona Beach, May 1, 2 and 3, was 620; members, 380; visiting doctors, 31; exhibitors, 65; Woman's Auxiliary, 144.

### REGISTRATION LIST

#### OFFICERS

SPIERS, W. HENRY, President. . . . . *Orlando*  
ROBINSON, LEIGH F., President-elect. . . *Ft. Lauderdale*  
WEILAND, ARTHUR H., First Vice-Pres. *Coral Gables*  
WELLS, J. RALSTON, 3rd Vice-President, *Daytona Beach*  
RICHARDSON, SHALER, Secretary-Treasurer, *Jacksonville*  
THOMPSON, STEWART G., Managing Director, *Jacksonville*

#### MEMBERS AND GUEST DOCTORS

*Apopka*: T. E. McBride. *Arcadia*: J. A. Simmons.  
*Baldwin*: W. D. Brinson. *Bay Pines*: Orville N. Nelson. *Bradenton*: M. M. Harrison, S. G. Hollingsworth, C. W. Larrabee, W. D. Sugg. *Brooksville*: G. R. Creekmore. *Bunnell*: Donald T. Rankin. *Canal Point*: Wilburn C. Young. *Carrabelle*: Chapman Dykes. *Century*: J. I. Turberville, J. S. Turberville. *Chattahoochee*: J. C. Robertson, Ralph E. Stevens. *Cocoa*: T. C. Kenaston, Walter C. Page. *Coral Gables*: Warren W. Quillian. *Cross City*: James M. Anderson. *Dade City*: W. Wardlaw Jones. *Dania*: Paul G. Shell.

*Daytona Beach*: Onie Ann Barrett, J. R. Chandler, C. A. Clemmer, R. Cuthbertson, C. W. Davis, Joseph B. Davis, A. E. Drexel, P. A. Drohomier, L. W. Glatzau, George M. Green, Raymond Howe, Roy Howe, L. A. Jeffery, Harry L. Merryday, R. L. Miller, M. J. Myres, Fred Puleston, J. E. Rawlings, M. Josie Rogers, Joseph H. Rutter, Morris B. Seltzer, Maximilian Stern, J. R. Vallotton, Ludo von Meysenbug, Evans B. Wood.

*DeLand*: L. V. L. Brown, George A. Davis, Theodore F. Hahn, W. C. Pay, Joseph E. Taylor, C. E. Tribble, Hugh West, W. J. Williams. *Dunedin*: H. E. Winchester. *Dunnellon*: Carl S. Lytle, B. S. Stuts. *Eustis*: C. M. Tyre, R. H. Williams. *Ft. Lauderdale*: Anna A. Darrow, L. B. Elliston, R. L. Elliston, E. M. Hendricks, J. W. McMurray, H. J. Peavy, C. H. Sory, L. L. Stepp. *Ft. Meade*: G. H. Carefoot. *Ft. Pierce*: H. D. Clark, Francis A. Gowdy, L. L. Whiddon.

*Gainesville*: Chester F. Ahmann, Edwin H. Andrews, Alva T. Cobb, Jr., J. Maxey Dell, Jr., Wilburn Lassiter, John E. Maines, Jr., Thomas A. Snow, J. L. Summerlin, W. C. Thomas, G. C. Tillman. *Grandin*: Z. Brantley. *Holly Hill*: C. O. Sayres.

*Jacksonville*: J. A. Beals, Terry Bird, J. B. Black, J. L. Boone, O. P. Broadbent, W. H. Brooks, Alan Brown, Thomas E. Buckman, T. Z. Cason, B. A. Chapman, F. V. Chappell, Adolph Cone, Daniel N. Cone, George W. Croft, L. Y. Dryenforth, Thomas S. Field, Frank L. Fort, J. V. Freeman, Dan H. Funkenstein, J. E. Gammon, Karl B. Hanson, O. E. Harrell, W. G. Harris, Charles F. Henley, Graham E. Henson, Gerry R. Holden, Luther W. Holloway, V. A. Hughes, R. Hutchinson, Gordon H. Ira, Edward Jelks, S. I. Kemp, F. G. King, Raymond H. King, J. L. Kirby-Smith, L. Sydnor Laffitte, Louie Limbaugh, T. H. Lipscomb, A. J. Logie, John F. Lovejoy, J. G. Lyerly, A. B. McCreary, W. H. McCullagh, R. L. McDaniel, H. B. McEuen, R. B. McIver, Charles B. Mabry, W. S. Manning, A. M. Manson, J. Webster Merritt, Kenneth A. Morris, George W. Morse, G. F. Oetjen, Thomas M. Palmer, J. N. Patterson, Harry A. Peyton, L. B. Provinsky, J. H. Randolph, Ferdinand Richards, George W. Richardson, William E. Ross, E. T. Sellers, W. McL. Shaw, Frank G. Slaughter, Lauren M. Sompayrac, Thomas Z. Stanley, W. M. Stinson, Edwin C. Swift, H. Marshall Taylor, Edmund H. Teeter, H. D. Van Schaick, F. J. Waas, E. C. Watt, Joseph Weinreb, C. R. Wilcox, J. F. Wilson, B. F. Woolsey.

*Kissimmee*: T. M. Rivers. *Lacoochee*: W. H. Walters, Jr., *Lake Butler*: J. E. Maines, Sr. *Lake City*: Thomas H. Bates, R. B. Harkness, Harry S. Howell. *Lakeland*: J. R. Boulware, Jr., R. L. Cline, John J. Jares, Jr., John G. Lester, G. C. Overstreet, W. L. Tillis, Herman Watson, W. A. Weed. *Lake Wales*: R. E. Wilhoyte. *Leesburg*: Leroy H. Oetjen, M. B. O'Kelley. *Live Oak*: T. S. Anderson, Irby Black. *McIntosh*: J. L. Strange. *Manatee*: T. M. McDuffee. *Melbourne*: I. F. Bean, George H. Benton, I. M. Hay.

*Miami*: Julius Alexander, Lassar Alexander, J. L. Anderson, H. A. Barge, G. E. Chandler, M. M. Coplan, C. E. Dunaway, Elmo D. French, Francis W. Glenn, John E. Hall, Laura M. Hobbs, B. F. Hodsdon, Walter C. Jones, Jr., R. Lefholz, A. G. Levin, J. H. Lucinian, R. O. Lyell, E. N. McKenzie, Jack A. McKenzie, W. W. McKibben, James H. Mendel, Frank R. Morrow, W. G. O'Donnell, Colquitt Pearson, Homer L. Pearson, Jr., Nelson T. Pearson, C. L. Perry, Edgar Peters, Kenneth Phillips, Gerard Raap, S. Marion Salley, Wiley M. Sams, E. Clay Shaw, John W. Snyder, Franz Stewart, Joseph S. Stewart, C. E. Tumlin, P. B. Welch, Iva C. Youmans.

*Miami Beach*: E. H. Adkins, Ralph A. Gowdy, A. R. Hollender, George N. Leonard, W. Duncan Owens, Frazier J. Payton, N. O. Pearce, Robert E. Repass, Harrison A. Walker, Arthur L. Walters. *New Smyrna Beach*: Louis B. Bouchelle, W. C. Chowning, H. W. Henry, B. E. Miller, H. E. Miller, H. Z. Silsby. *Ocala*: J. L. Chalker, Henry C. Dozier, R. D. Ferguson, C. W. Mimms, John N. Moore, Ralph E. Russell, T. H. Wallis, Harry F. Watt.

*Orlando:* Claude Anderson, H. M. Beardall, Russell B. Carson, John R. Chappell, L. N. Christensen, C. J. Collins, Horace A. Day, Spencer A. Folsom, L. Paul Foster, William O. Fowler, Frank D. Gray, F. H. Harms, John R. Hatfield, Carl D. Hoffmann, Hollis C. Ingram, Hewitt Johnston, J. A. Kelk, L. H. Kingsbury, A. C. Kirk, Carl J. Larsen, Duncan T. McEwan, John S. McEwan, Meredith Mallory, Fred Mathers, T. A. Neal, L. M. Orr, II, Gilbert S. Osincup, W. Grady Page, J. A. Pines, Don C. Robertson, Joseph G. Seltzer, W. E. Sinclair, Ross Stromberg, D. D. S., L. M. Sutter, B. E. Taylor, E. J. Teagarden, R. D. Thompson, Richard H. Walker, Jr., Roland T. White, Carolyn G. Williamson, Sanford L. Zieve.

*Oviedo:* J. William Martin. *Palatka:* F. Emory Bell, C. M. Knight. *Palm Beach:* B. B. Sory, Jr. *Panama City:* William C. Roberts, Henry D. Smith. *Pensacola:* Charles A. Born, Herbert L. Bryans, Luther C. Fisher, Jr., James M. Hoffman, M. A. Lischkoff, J. J. McGuire, J. H. Pierpont, Carol C. Webb. *Pierson:* P. L. Moon, Jr.

*Plant City:* J. W. Alsobrook, Edgar Austin, T. C. Maguire. *Pompano:* George S. McClellan. *Raiford:* W. E. Murphree. *St. Augustine:* Reddin Britt, Charles C. Grace, V. A. Lockwood, G. Walter Potter, Herbert E. White.

*St. Petersburg:* William M. Davis, O. O. Feaster, C. S. Franckle, L. M. Gable, W. W. Harden, Prescott LeBreton, W. C. McConnell, E. C. MacCordy, Norval M. Marr, A. L. Mills, D. F. H. Murphey, R. W. S. Owen, J. B. Quicksall, Alvin J. Wood. *Sanford:* John T. Denton, A. W. Knox, Thomas F. McDaniel, Charles L. Park, G. S. Selman, J. N. Tolar. *Sarasota:* Joseph Halton, David R. Kennedy, T. W. Taylor. *Sebastian:* David Rose. *Sebring:* H. V. Weems. *Stuart:* Van W. Burns.

*Tallahassee:* George W. Brown, Jr., L. L. Dozier, F. T. Holland, J. Kent Johnston, H. E. Palmer, J. H. Pound, B. A. Wilkinson.

*Tampa:* Frank S. Adamo, W. P. Adamson, C. A. Andrews, A. M. Bidwell, G. C. Bottari, H. O. Brown, L. F. Carlton, George L. Cook, E. M. Corlew, James T. Cowart, J. C. Dickinson, Rosalind E. Ebersbach, J. L. Estes, S. B. Forbes, C. M. Gray, J. C. Griffin, Jr., J. J. Guerra, S. P. Gyland, James P. Harmon, John S. Helms, Jr., Rollin Jefferson, A. R. Knauf, Douglas D. Martin, David R. Murphey, Jr., W. M. Rowlett, C. A. Rudisill, H. Mason Smith, N. L. Spengler, Joseph W. Taylor, J. C. Vinson.

*Vero Beach:* E. B. Hardee, Joseph B. Kollar. *West Palm Beach:* George M. Dawson, W. W. George, F. K. Herpel, V. M. Johnson, Kenneth Montgomery, L. J. Netto, J. H. Pittman, L. M. Rozier, William Y. Sayad, James R. Sory, William H. Weems. *Winter Park:* Ruth S. Hart.

*District of Columbia:* C. E. Rice. *Georgia—Atlanta:* W. W. Anderson, Joseph Yampolsky. *Canton:* C. R. Andrews, Jr. *Shady Dale:* E. M. Lancaster. *Illinois—Chicago:* M. T. MacEachern. *Michigan—Detroit:* Randall M. O'Rourke, Wayne A. Yoakam. *Newberry:* H. E. Perry. *New York—Malone:* G. F. Zimmerman. *New York City:* Joseph E. J. King, Robert A. Wise. *North Carolina—Greensboro:* M. MacFadyen. *Virginia—Portsmouth:* Joseph D. Collins.

#### EXHIBITORS

Abernathy, J. H., Southeastern Optical Co., Jacksonville  
Anderson, Gunnar, Miami Surgical Company, Miami  
Anderson, T. Emmett, Surgical Supply Co., Tampa  
Avery, W. E., C. B. Fleet Company, Lynchburg, Va.  
Barnett, A. T., Eli Lilly & Company, Atlanta, Ga.  
Britt, Walter S., Surgical Supply Company, Jacksonville  
Britton, Guy, Surgical Supply Company, Orlando  
Brown, Harry, Table Rock Laboratories, Jacksonville  
Burnett, Miss Pauline M., Coca-Cola Co., Daytona Beach  
Butzer, G. I., Everhart Surgical Supply Co., Orlando  
Byrd, R. W., Surgical Supply Co., Miami  
Campbell, Allan, Surgical Supply Co., Orlando

Casey, Allen M., Wm. S. Merrell Co., Tampa  
Caven, J. W., Surgical Supply Co., Jacksonville  
Cuthbert, Guy E., Surgical Supply Co., Tampa  
DeBardelaben, J., Lederle Laboratories, Inc., Atlanta, Ga.  
DeBoer, R. H., Parke, Davis & Co., St. Petersburg  
Capps, C. Glynn, Southeastern Optical Co., Macon, Ga.  
Carter, J. M., Petrolagar Laboratories, Tampa  
Fassett, L. W., White Belt Dairy Laboratories, Miami  
Flynn, William D., American Optical Co., Jacksonville  
Gillmore, J. H., Mead Johnson & Co., Atlanta, Ga.  
Graham, Douglas, E. R. Squibb & Sons, Atlanta, Ga.  
Heether, Hans B., Kelceket X-Ray Co. of Fla., Miami  
Hirsch, E. S., Southeastern Optical Co., Miami  
Hunt, Wayne C., Kelceket X-Ray Co. of Fla., Jacksonville  
Jensen, P. A., Westinghouse X-Ray Co., Atlanta, Ga.  
Jongedyk, P., General Electric X-Ray Corp., Miami  
Kealan, Harry S., Philip Morris & Co., New York, N. Y.  
Keller, R. D., Southeastern Optical Co., Rochester, N. Y.  
Kelley, D. C., Jr., Surgical Supply Co., Jacksonville  
Knight, Miss Louise, Bard-Parker Co., Daytona Beach  
Lester, O. D., Lederle Laboratories, Inc., Jacksonville  
Lindley, J. E., E. R. Squibb & Sons, Coral Gables  
McCormick, W. J., Coca-Cola Co., Daytona Beach  
Mabry, Jerry L., Miami Surgical Co., Miami  
Mackel, S. C., General Electric X-Ray Corp., Jacksonville  
Merrihew, J. S., Jones Metabolism Equip. Co., Miami  
Miller, D. L., A. S. Aloe Co., St. Louis, Mo.  
Mills, Dr. C. F., H. G. Fischer Co., Chicago, Ill.  
Moore, Charles B., Bard-Parker Co., Danbury, Conn.  
Nelson, A. C., Westinghouse X-Ray Co., Miami  
Nichelson, H. B., American Optical Co., Miami  
O'Shea, Kathryn, Philip Morris & Co., Daytona Beach  
Papineau, Q. J., Pet Milk Co., St. Louis, Mo.  
Parramore, Henry L., Surgical Supply Co., Jacksonville  
Pynchon, Mrs. May, Fla. Tuberculosis and Health Assn., Jacksonville  
Rader, E. E., M & R Dietetic Lab., Columbus, Ohio  
Regan, F. A., Parke, Davis & Co., Tampa  
Sample, D. H., Kelceket X-Ray Company of Fla., Tampa  
Scott, M. B., Jr., Eli Lilly & Co., Jacksonville  
Shipley, John A., Wm. S. Merrell Co., Cincinnati, Ohio  
Spahn, Phil. J., Pet Milk Co., Jacksonville  
Spitze, Harold, General Electric X-Ray, Atlanta, Ga.  
Swanson, Charles, Pet Milk Co., St. Louis, Mo.  
Swanson, Frank, Pet Milk Co., Atlanta, Ga.  
Thomas, R. H., Westinghouse X-Ray Co., Jacksonville  
Thompson, A. F., H. G. Fischer Co., Chicago  
Thompson, Byron, Surgical Supply Co., Jacksonville  
Thompson, Ray, Surgical Supply Co., Miami  
van Weintraub, M. N., Miami Surgical Co., Miami  
Walker, D. W., Everhart Surgical Supply, Atlanta, Ga.  
Weaver, M. H., American Optical Co., Jacksonville  
Williams, L. V., J. B. Lippincott Co., Philadelphia, Pa.  
Wood, J. Forrest, J. Sklar Mfg. Co., Lexington, Ky.

#### WOMAN'S AUXILIARY

*Arcadia:* Mrs. John A. Simmons. *Baldwin:* Mrs. W. D. Brinson. *Bartow:* Mrs. C. H. Murphy. *Brooksville:* Mrs. G. R. Creekmore. *Century:* Mrs. J. I. Turberville. *Chattahoochee:* Mrs. Ralph E. Stevens. *Cocoa:* Mrs. T. C. Kenaston. *Cross City:* Mrs. Sam Moorner. *Daytona Beach:* Mrs. J. R. Chandler, Mrs. Charles A. Clemmer, Mrs. J. B. Davis, Mrs. L. W. Glatzau, Mrs. Dorothy F. Henson, Mrs. Roy Howe, Mrs. W. E. Hunt, Mrs. F. R. Marron, Mrs. H. L. Merryday, Mrs. R. L. Miller, Miss Louise Miller, Mrs. M. J. Myres, Mrs. Fred Puleston, Mrs. George Roy, Hester Shaw, Mrs. Maximilian Stern, Mrs. C. H. Talton, Mrs. J. R. Vallotton, Mrs. Ludo von Meysenbug, Mrs. J. Ralston Wells, Mrs. Evans B. Wood. *DeLand:* Mrs. L. V. L. Brown, Mrs. G. A. Davis, B. Henderson, Mrs. J. E. Taylor. *Dunnellon:* Mrs. C. S. Lytle. *Ft. Lauderdale:* Miss Patti B. King, Mrs. J. W. McMurray, Mrs. Leigh F. Robinson. *Ft. Meade:* Mrs. G. H. Carefoot. *Ft. Pierce:* Mrs. F. A. Gowdy. *Gainesville:* Mrs. Thomas A. Snow, Mrs. J. L. Sumnerlin.



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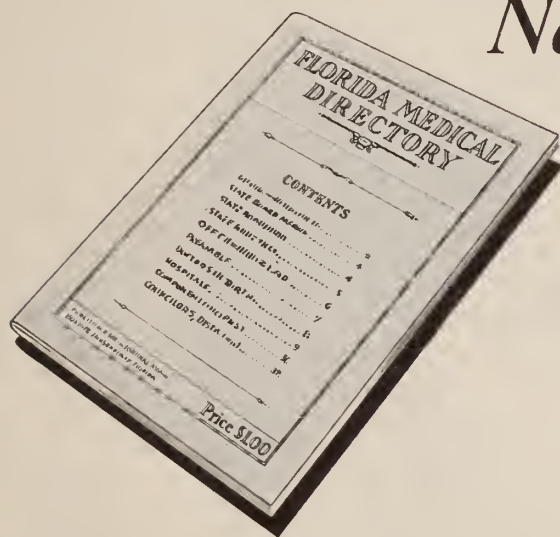
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## OUR PRESIDENT

Dr. Leigh Fowler Robinson of Ft. Lauderdale was inducted into the presidency of the Florida Medical Association at the Annual Meeting held in Daytona Beach, May 1, 2, and 3. This honor comes as a culmination of many years of service to the Association.

Doctor Robinson was born June 20, 1887, at Martinsville, Indiana, the son of Joseph M. and Alice Fowler Robinson. He attended the University of Indiana from 1906 to 1910 and then entered Jefferson Medical College from which he graduated in 1912. His internship was served at the Gouverneur Hospital, New York City, and at the Methodist Hospital at Philadelphia. For two years following his internship, he was assistant to Drs. T. B. Eastman and H. A. Moore of Indianapolis. He then became Assistant Physician of the State Hospital at Skillman, New Jersey, and later held the same position at the State Hospital at Raleigh, N. C. He was married to Miss Dorothy Barrows in July, 1916.

Doctor Robinson served with the Marines from 1917 to 1920 as Surgeon, U. S. Navy, and went to Santo Domingo with the Marine Expeditionary Forces. On his return from government service, he accepted the position

of Surgeon and Director of the La Humanitaria Hospital of the Dominican Republic, in 1920, where he remained for five years.

In 1925 Doctor Robinson came to Florida to engage in private practice at Ft. Lauderdale. He very soon became prominent in medical circles in this state, serving as president of the Broward County Medical Society and of the East Coast Medical Association. The State Association, recognizing his ability, made him councilor from his district in 1931 which was followed by membership in and then the chairmanship of the Executive Committee. For three years he served as chairman of the Committee on Scientific Work and was then made president-elect.

Besides affiliation with his county, state and national medical societies, Doctor Robinson holds membership in the Southern Medical Association, the Southeastern Surgical Congress, the American Proctological Society and Fellowship in the American College of Surgeons. He is a member of the Phi Rho Sigma fraternity, the F. and A. M.; B. P. O. E.; a past commander of the local post of the American Legion; and a member of the Rotary Club.

Valuable contributions have been made to the medical literature by Doctor Robinson whose articles have appeared in the Journal of the American Medical Association, the Journal of the Florida Medical Association, the New Jersey Medical Journal, the Medical Record, the Naval Medical Bulletin, the Southern Medical Journal and in Anesthesia and Analgesia.

## FLORIDA BASIC SCIENCE LAW

The act to be known as the Florida Basic Science Law states that the term, "basic sciences" shall mean the following subjects: anatomy, physiology, chemistry, pathology and bacteriology. Section 4 provides that no person shall hereafter be eligible for examination or permitted to take an examination for a license to practice the healing art or any branch thereof or be granted any such license unless and until he has presented to the licensing board or other authority empowered to issue such license, a certificate of proficiency in the basic sciences as provided in this act. This law is not retroactive; persons now holding Florida



licenses to practice the healing art are not affected by it.

Sections 3 and 6 provide for the establishment of a board of examiners in the basic sciences. The Governor shall, within thirty days after this act takes effect, appoint a board of examiners in the basic sciences consisting of five members learned in the basic sciences designated. These five members are to be appointed from the faculties of the universities and colleges in Florida having four-year courses. Not more than two members of the board shall be appointed from the faculty of any one of the universities or colleges.

Section 9 provides that the chairman of the board shall arrange the place in which to conduct the examination, which shall be at one of the universities or colleges represented by the members of the board. Section 11 provides a fee of \$10.00 for examination or any re-examination by the board. Section 12 provides that no person shall be eligible for examination for a certificate of proficiency until he shall have furnished satisfactory evidence that he is a citizen of the United States of America, is of good moral character and is a graduate of an accredited high school or possesses the educational qualifications equivalent to those required for graduation from an accredited high school.

Section 13 provides that applications for examination shall not contain questions to be answered by the applicant, which will disclose the professional school he may have attended or what system of treating the sick he intends to pursue. Section 15 provides that examinations shall be held twice each year, approximately six months apart, and that every examination shall be conducted in writing in English. Section 18 provides that each certificate of proficiency in the basic sciences shall be in the form prescribed by the board, under the name and seal of the board and signed by its chairman and secretary.

The complete text of the Florida Basic Science Law will appear in your new Florida Medical Directory which will be published about the later part of January. Members of the Association who wish to study this new law prior to its publication may secure a mimeographed copy by application to Box 1018, Jacksonville.

## ASSOCIATION'S ANNUAL MEETING

The Daytona Beach Convention, which was the Association's Sixty-sixth Annual Meeting, was an occasion which will long be remembered. The total registration was 620. Of that number 380 were members of the Association; 31 were visiting doctors; 144 were members and guests of the Woman's Auxiliary; and 65 were representatives of exhibiting firms.

The officers and members of the Volusia County Medical Society worked untiringly for many months preceding, as well as during the entire convention, providing for the comfort and pleasure of their guests, and making arrangements for the many business and scientific sessions.

On Monday forenoon, the first meeting of the House of Delegates convened at 9 o'clock and continued until noon. Dr. Meredith Malory of Orlando was re-elected delegate to the A. M. A. for a term of two years; Dr. Homer Pearson of Miami was elected his alternate. A number of resolutions were adopted which appear in this issue of the Journal as part of the proceedings. Upon recommendation of the Executive Committee and the Council, a charter was granted to a new society which will be known as the Franklin-Gulf County Medical Society. The meeting place for the 1940 annual convention was designated as Tampa, on recommendation of the Executive Committee. Carefully prepared annual reports from eighteen of the Association's standing committees were read by the various chairmen. These reports will be found in this issue of the Journal.

Annual meetings and scientific sessions of allied groups were held Sunday afternoon and Monday forenoon. The groups holding annual meetings were the Florida Radiological Society, the Florida Pediatric Society, the Florida Railway Surgeons' Association, the Florida Society of Dermatology and Syphilology, and the Florida Section of the Southeastern Surgical Congress. These allied groups have held regular annual meetings in previous years. Organization meetings were held by two other groups, who elected officers and enjoyed programs: the Florida Internists' Society and the Florida Association of Industrial Surgeons. The ophthalmologists and otolaryngologists present held an informal meeting.

At the scientific assemblies, which were well

attended, seventeen excellent papers were presented, all of which will be published in your Journal some time during the year. The guest speaker of the Association, secured through President W. Henry Spiers, was Dr. Joseph E. J. King, Director of Neurosurgery at Bellevue Hospital, Lenox Hill Hospital, New York Polyclinic Hospital, and the Hospital for the Ruptured and Crippled, New York City. Doctor King's address on "Brain Abscess" was a feature of the Wednesday forenoon session.

The Ladies' and Gentlemen's Jamboree, held Monday evening at the Pier Casino, was a delightful occasion, made possible by the elaborate preparations of the local committee on arrangements. On Tuesday evening the Association's annual dinner was held at the Princess Issena Hotel, with an attendance of 287. The large dining room was beautifully decorated and the toastmaster, Judge Herbert B. Frederick, kept the audience in an uproar with his ready wit.

The three scientific exhibits were a credit to any medical gathering. Those in charge of the following exhibits received the commendation of the large attendance during the convention: the Florida Society of Dermatology and Syphilology, the Florida Tuberculosis Sanatorium, and the Florida Woman's Field Army of the American Society for the Control of Cancer. There were 29 technical exhibits which contributed to the success of the convention, not only from the standpoint of their displays and the splendid personnel of representatives, but also through their financial aid in defraying convention expenses. The exhibit booths were uniformly draped in royal purple and silver, which set off the displays to better advantage than at any previous meeting.

To Mr. Henry Haynes, owner-manager of the Princess Issena Hotel, and his assistants, the Association is deeply grateful for splendid service and unfailing cooperation which ironed out many of the little difficulties that are apt to creep into a meeting of this size.

A resolution was unanimously passed by rising vote, according hearty thanks to the members of the Volusia County Medical Society, their wives, the officials of the City of Daytona Beach, and others who made possible the outstanding occasion which was the Sixty-sixth Annual Convention of the Association.

## ALLIED GROUP NOTES

### FLORIDA INTERNISTS' SOCIETY

The Florida Internists' Society was organized at Daytona Beach, May 1, 1939, as an allied group composed of members of the Florida Medical Association. The first official meeting was held prior to the Florida Medical Association's annual convention at Daytona Beach. The following officers were elected: president, Norval M. Marr, St. Petersburg; secretary, Kenneth Phillips, Miami. It is planned to have an annual meeting of this allied group each year in the convention city at the time of the Florida Medical Association's annual meeting.

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### FLORIDA ASSOCIATION OF INDUSTRIAL SURGEONS

The Florida Association of Industrial Surgeons was organized at Daytona Beach, May 1, at a meeting at which the following doctors were present: Arthur H. Weiland, Coral Gables; J. R. Vallotton and J. Ralston Wells, Daytona Beach; Leigh F. Robinson and C. H. Sory, Ft. Lauderdale; B. A. Chapman and G. F. Oetjen, Jacksonville; Herman Watson, Lakeland; Gail E. Chandler, F. W. Glenn and C. E. Tumlin, Miami; Harrison A. Walker, Miami Beach; H. A. Day, Orlando; Herbert L. Bryans, Pensacola; J. W. Alsbrough, Plant City; Joseph Halton, Sarasota; and A. M. Bidwell, Tampa.

The following officers were elected: president, C. E. Tumlin; vice president, Harrison A. Walker; secretary, A. M. Bidwell, and treasurer, G. F. Oetjen.

This new allied group should be of benefit to the whole of Florida as well as to all the doctors doing this type of work.

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### FLORIDA RADIOLOGICAL SOCIETY

The annual meeting of the Florida Radiological Society was held at the Princess Issena Hotel, Daytona Beach, April 30 and May 1, with the president, Dr. H. O. Brown, presiding. The following members were present: Drs. J. M. Dell, Jr., J. C. Dickinson, O. O. Feaster, E. M. Hendricks, F. K. Herpel, T. H. Lipscomb, J. H. Lucinian, H. B. McEuen, J. J. McGuire, J. N. Moore, F. J. Payton, N. T. Pearson, J. A. Pines, Gerard Raap, W. McL. Shaw, and W. A. Weed. Associate



members: Drs. Turberville. Visitors: Drs. Beals, Gray, Halton, Jares and Levin.

Dr. J. J. Guerra, guest speaker on the program, presented case histories, illustrated by films, demonstrating differential diagnosis of perinephritic abscess. One meeting was devoted to the presentation of interesting films, followed by a round-table discussion; another session was devoted to a discussion of the therapeutic effect of radiology.

Officers for the ensuing year are: president, H. B. McEuen, Jacksonville; vice-president, Joseph H. Lucinian, Miami; secretary-treasurer, John N. Moore, Ocala. Meetings are held in November and at the annual convention of the Florida Medical Association in the Spring.

#### OPHTHALMOLOGY AND OTOLARYNGOLOGY

The ophthalmologists and otolaryngologists attending the meeting of the Florida Medical Association at Daytona Beach gathered informally while there and decided to hold a dinner meeting at the time of the annual convention of the Florida Medical Association at Tampa, but not in conflict with the Association's regular sessions. At that time, plans are to be discussed for forming a permanent organization.

It was decided to have four scientific papers presented, two pertaining to ophthalmology and two to otolaryngology. Dr. S. B. Forbes was chosen to act as temporary chairman in charge of the arrangements for the meeting. Suggestions or inquiries regarding the meeting and the organization of this new society may be addressed to him at 409 Citizens Bank Building, Tampa.

The physicians who attended the informal, preliminary meeting were: Drs. Joseph B. Davis, L. W. Glatzau and R. L. Miller, Daytona Beach; J. L. Summerlin, Gainesville; Shaler Richardson and H. Marshall Taylor, Jacksonville; R. L. Cline and W. L. Tillis, Lakeland; G. E. Chandler and J. H. Mendel, Miami; Robert E. Repass, Miami Beach; H. C. Ingram, Hewitt Johnston and W. G. Page, Orlando; H. D. Smith, Panama City; M. A. Lischkoff, Pensacola; George W. Brown, Tallahassee; S. B. Forbes and Joseph W. Taylor, Tampa; William Y. Sayad, West Palm Beach.

#### CONVENTION ECHOES

The sixty-sixth convention is over and nothing remains but memories. If the rest of the State enjoyed it as much as we did in entertaining, Volusia is well repaid. It was a grand convention. Of course everything did not go exactly as it was planned but everyone did his best and the sum total was good. It would not have been possible except for the loyal cooperation of every member of the local society. The Cabinet met frequently and each committee functioned smoothly. Some had more to do than others but everyone did his job and did it well.

Looking back several high lights stand out. The loud speaker used in making announcements saved many steps, much confusion and valuable time. The projecting lantern for information did silent and efficient work in the scientific session auditorium. The loud speaker setup in the same auditorium helped to make each address clear and thus more interesting. The arrangement of the booths for exhibitors, being uniform and neat, added much to the showmanship of the various exhibiting firms.

The Princess Issena Hotel accommodations were of the best and Mr. Haynes' genial manner helped very materially in keeping everybody happy. The ladies did themselves proud and I am told the luncheon and tea were a great success.

I wish to thank the committees and especially the Cabinet Committee for their untiring efforts. The assistance, both in time and money, of the City Commission contributed in no small degree and we thank them. The Coca-Cola Company in supplying everyone with a "cold bottle" at all times, even into the wee small hours, was extremely courteous and we thank the Company and especially their local manager, Mr. W. J. McCormick. If I kept on thanking everyone who contributed to the whole ensemble. I would have to take an extra page but I cannot close without mentioning our efficient, witty, and shall I say, slightly "risque" toastmaster, Judge Herbert B. Frederick. He was the right man in the right place even though he did tamper with facts both present and future.

J. RALSTON WELLS,  
*General Chairman.*

#### SPORTS' COMMITTEE

MAXIMILIAN STERN, *Cabinet Member*

Now that the big event has gone into history the members of the Sports' Committee of the Daytona Beach Convention feel that they will miss the close companionship which golf, skeet shooting and fishing brought to them for a few days with their out-of-town colleagues.

For the skeet shooters, I am especially anxious to speak, as it was the unanimity of opinion that this group should remain intact and add to its numbers from year to year as the State Association meets. It was the hope of several shooters that this organization might grow to compete with the golfers, especially as skeet shooting is increasing in popularity and gives promise of taking from golf many of its most enthusiastic devotees in the near future.

An interesting and very amusing characteristic of the skeet shooters was brought out at our shoot when the handicaps were being arranged. Even the "crack" shots in all modesty made claims for low scores and high handicaps.

Those who shot were:

C. A. Andrews	Hugh West
H. M. Beardall	Reddin Britt
V. M. Johnson	J. E. Maines, Jr.
Maximilian Stern	S. M. Sally
T. A. Snow	

The following firms contributed very appropriate prizes, and it is with pleasure that I acknowledge their enthusiastic cooperation in this event:

Abbott Laboratories, General Electric X-Ray Corp.,  
Southeastern Optical Co. Becton, Dickinson & Co.,  
Miami Surgical Company, Everhart Surgical Supply Co.,  
Seabreeze Drug Store, Surgical Supply Co.

Once more, let me urge that an effort be made when we meet in Tampa to re-organize the skeet shooters, as I am convinced that no branch of sport can bring out a finer feeling of fellowship and accentuate more nearly the principles for which the Florida Medical Association stands.

#### COMMITTEE ON ALUMNI AND FRATERNITY LUNCHEONS

M. J. MYRES, *Chairman*

Another meeting of the Florida Medical Association has passed into history and with it the luncheons of the old grads. The function was well attended, southern colleges, of course, drawing the majority of the visitors. Emory University and the Phi Beta Kappa withdrew for secret conclaves, while representatives of the other colleges and fraternities formed groups near the placards bearing their names. Many renewed old friendships or made new contacts. Talk was largely of "old Bill," or "what is Jones doing?", "how is your son making out," etc.

These functions really are a delightful and necessary part of our annual meeting and this Committee is highly gratified with the good response and splendid attendance of our guests. We feel amply repaid for the little trouble we had in making the necessary arrangements.

#### GOLF COMMITTEE

J. R. CHANDLER, *Chairman*

A total of 48 golfers competed for the rotating Orlando Handicap Trophy and the other merchandise valued at more than \$250.00. There were prizes for every doctor who played in the tournament. However, every doctor did not win a prize much to the displeasure of the local golf committee. We were unable to control the scores and see that every one presented a just handicap.

The Orlando Cup was won by Dr. J. T. Cowart of Tampa; and second prize by Dr. C. A. Rudisill, also of Tampa. This was a golf bag donated by Van Pelt & Brown of Richmond Va. Doctor Cowart had a gross score of 80. His handicap of 16 gave him a net 64. Doctor Rudisill won the second prize with a gross score of 78.

Thirty-three golfers competed in the Blind Bogey Tournament. The first draw for the lucky score was 78. Not a player had that score so a second draw was made. This time it was 75 with four doctors tied. In the draw Doctor Shaler Richardson won first prize of \$22.00 and Doctor Cowart second prize of \$11.00. Dr. F. D. Gray and Dr. J. R. Quicksall were the unlucky ones.

The following were donors of our prize list: New Yorker Bar & Grill, Stephen's Drug Co., Al Sherman's, Hubert's Drug Co., Walgreen's Drug Co., Liggett's Drug Co., Sun Pharmacy, Abernethy's, Eli Witt Co., H. R. Hegenwald, Petrolagar Lab., Bay Street Pharmacy, E. R. Squibb & Sons, Professional Golf Co., Paul's Pharmacy, Van Pelt & Brown, Bogart Pharmacy, Prescription Shop, Bishop's Pharmacy, Mayfair Bar & Grill, Halifax Motors, General Electric, Everhart Surgical Supply Co., Armour Lab., Nestle's Milk, Mead Johnson Co., Phillip Morris, John Wyeth & Brother, Hart Drug Co., Wm. A. Webster Co., Boehm Surgical Corporation, Becton Dickinson, Abbott Laboratories, A. Stein & Co., Duke Laboratories, Dunn Bros., Kahn's, Daytona Book Store, Yowell-Drew Co., Similac, Gary Drug Co., Wm. S. Merrell Co., Sears, Roebuck & Co., The Upjohn Co., Doby's, Miami Surgical Co., American Optical Co., Surgical Supply Co., Sharp & Dohme, Daytona Motor Co., and Charlie's Grill & Cocktail Bar.

#### MEDICAL ETHICS' VALUE IN PROTECTING PUBLIC RECOGNIZED

FEDERAL JUDGE'S CHARGE TO JURY IN SUIT  
OF BRINKLEY AGAINST *HYGEIA'S* EDITOR  
POINTS TO SIGNIFICANCE OF CODE

The significance of medical ethics for the protection of the public is well emphasized by the charge to the jury, made by Federal Judge R. J. McMillan recently at Del Rio, Texas, in the case of John R. Brinkley's libel and damage suit against Morris Fishbein, M. D., editor of *Hygeia*, *The Health Magazine*, wherein a verdict was returned in favor of Dr. Fishbein, *The Journal of the American Medical Association* for June 3 points out.

*The Journal* has been publishing in instalments the proceedings of the trial, which attracted wide attention because it involved the question of absolute privilege under the law of libel where the defense was truth and the protection of the public health. Pointing out that its June 3 issue contains the final instalment of the proceedings, *The Journal* says:

"Most significant is the charge of Judge R. J. McMillan to the jury which rendered the verdict in this case. The entire charge merits most careful consideration; indeed, some of the statements might well be read to the senior class of every medical college in this country. Particularly to be considered is that section of the charge dealing with medical ethics. Here the judge said, and it is repeated for emphasis:

In determining what is professional and not professional conduct of the physician, you may take into consideration the rules of ethics followed by the great majority of medical men and which are recognized generally in their profession. . . . The term as applied to the liberal professions, such as the practice of medicine or the practice of law, is generally understood to mean that course of conduct pursued by recognized moral practitioners either of medicine or law.

It doesn't necessarily follow that every slight deviation or change by a doctor or a lawyer from what the general body of the doctors or lawyers do would be unethical, but if his course of conduct was far beyond and contrary to the course of conduct which the other members of his profession followed, then you would say that he was unethical either in the practice of medicine or in the practice of law.

As the evidence here shows, it has practically always been considered unethical for physicians to advertise, that is to say, to advertise further than to call the attention of the public to the fact that they were there ready to practice, and by some character of card giving their location or address, or if they specialize in some particular kind of practice to so advise the public. Advertisements by which prizes are offered to secure patronage or by which claims are made of superior skill or ability are not ethical, and you may consider those matters in this case in passing on the question as to the



truth or falsity of the charge. In other words, it is one of the component elements that go to make up the question as to whether this man would be classified as a quack or not. It is not entirely determinative, but it may be that it is entitled to consideration. Accordingly, in determining what is professional and unprofessional conduct by a physician you are entitled to take into consideration the rules of ethics followed by the great majority of the medical men and which are generally recognized in their profession. The conduct of the plaintiff Brinkley should not be measured against his own personal ideas with regard to what is proper. It should be measured against the ethics and approved conduct of physicians generally, and to such extent that his conduct as a physician varies from the rules of ethics recognized and observed generally he becomes subject to criticism, and criticism of his conduct is privileged unless unduly excessive and the terms of the criticism are unreasonable or unfair.

"Thus a Federal Court has recognized the significance of medical ethics for the protection of the public, and the jury after due consideration placed its approval on the right of the public to have the protection that medical ethics affords."

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## STATE NEWS ITEMS

Dr. Ferdinand Richards, Jacksonville, was certified by the American Board of Obstetrics and Gynecology, after satisfactorily passing the examination held in St. Louis, Missouri, May 13.

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The Southeastern Section of the American Congress of Physical Therapy will hold a one-day scientific session on Monday, July 10, 1939, at the Hotel George Washington, Jacksonville. The morning and afternoon periods will be devoted to papers on diversified subjects. There will be an informal dinner in the evening followed by a symposium on "The Place of Physical Therapeutic Methods in Arthritis." There will be papers on Light Therapy, Radium and X-ray Therapy, Fever Therapy, Short-wave Diathermy and Exercise and Massage. Prominent clinicians will participate. Physicians and duly vouched-for technicians, registered nurses and hospital workers are eligible to attend. There will be no registration fee. For a program and other information address Dr. Kenneth Phillips, Secretary, Southeastern Section, American Congress of Physical Therapy, 609 Huntington Building, Miami, Florida.

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Dr. and Mrs. E. J. Melville of St. Petersburg left for Canada on May 23. They sailed from Montreal June 16 via C. P. R. for Bel-

fast. After touring Ireland, they will take the North Cape Cruise returning to New Orleans via Holland American Line from Rotterdam, after an absence of about five months.

\* \* \*

Dr. Samuel B. Strong, a major in the U. S. Army, who was until recently on the orthopedic and surgical staff of the Station Hospital, Fort Oglethorpe, Ga., has returned to Havana, Cuba, and opened offices at 310, Prado.

\* \* \*

Dr. Francis W. Glenn of the Tumlin Clinic, Miami, spent the month of May in Philadelphia, Pennsylvania, studying, and visiting clinics.

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The Orange County Medical Society announces that its annual picnic and barbecue will be held as usual this summer. The date will be announced later, although it will likely be in August. All members of the Florida Medical Association are cordially invited to attend this annual picnic and barbecue.

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Dr. Alpheus K. Wilson of Jacksonville took a postgraduate course in ophthalmology at the George Washington University, Washington, D. C., in April.

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Dr. A. R. Hollender, Miami Beach, addressed the Eastern Section of the American Congress of Physical Therapy, at Philadelphia, April 22, on "Controversial Problems in Nasal Iontophoresis;" and the Florida Internists' Society at Daytona Beach, May 1, on "Cooperative Management of Allergic Rhinitis."

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Dr. and Mrs. W. W. Massey of Quincy have returned from a trip to New York City where Doctor Massey attended the International Surgical Congress Assembly. He also attended the last meeting of the Southeastern Surgical Congress held in Atlanta.

\* \* \*

Dr. F. Gordon King of Jacksonville has returned from a month's intensive training course in intratracheal anesthesia at Toledo, Ohio. He studied under Drs. F. W. Clement and K. C. McCarthy, as temporary Resident in Anesthesia at the Lucas County Hospital.

On June 3, Dr. Rosalie Slaughter Morton of Winter Park received the honorary degree of "Doctor of Sciences" from Rutgers University in New Brunswick, N. J., which was bestowed "as a tribute to contributions to human welfare and a recognition of professional attainment."

### JOHN BALLARD TOWER

Dr. John Ballard Tower, for twenty-nine years a physician in South Florida, died at the Postgraduate Hospital, Homestead, April 13, after an illness of two years. All the people in the area joined in sorrow at the passing of the beloved practitioner and community leader.

A descendant of John and Priscilla Alden, Doctor Tower was born at Hoosac Tunnel, Mass., July 28, 1873. His parents, Alonzo Dennis Tower and Sophia Ballard Tower pioneered in Kansas 60 years ago and in the small farming town of Belvue, Kansas, John Tower grew to manhood.

Doctor Tower gained his higher education at Washburn College, Topeka, Kansas, where he received an A. B. degree in 1897, following which he attended the medical school at Northwestern University, receiving his M. D. degree in 1901, and being the president of his graduating class. He was a member of the Alpha Kappa Kappa, national honorary medical fraternity. Upon leaving college, Doctor Tower became resident physician at Alexian Hospital, Chicago, for two years. From there he went to the Rood Hospital, Hibbing, Minn., where he was superintendent of the medical department. He was licensed to practice medicine in Illinois, Minnesota, Kansas and Florida. After leaving Minnesota, he practiced in Topeka for four years. There he was instructor in embryology in the Kansas Medical College.

Seeking a warmer climate on account of ill-health, Doctor Tower came to Homestead in January, 1910, where he opened an office the following year. Throughout the years Doctor Tower made his rounds, delivering in that time some 1,400 babies in the Redland District.


Not alone for his medical services was Doctor Tower one of Homestead's greatest figures. He was identified with all civic and upbuilding activity. He served for years as a director of the Chamber of Commerce; was a charter member and president in 1934 of the Rotary Club; was president of the Homestead Building and Loan for 11 years; served 7 years on the City Council and 7 years as a school trustee. For 21 years he was the local surgeon for the F.E.C. Railroad. He was a member of the board of the Redland Citrus Exchange and at one time served as a director of the Florida Avocado and Persian Lime Growers' Association.

He was one of the twenty-five men who brought about the incorporation of the City of Homestead in 1913.

Doctor Tower continued his activity up until the last two years when serious illness afflicted him. Already he had become a legendary figure in the history of South Dade, well loved by the black people as well as the white.

Doctor Tower is survived by the widow, Mrs. Jane D. Tower, who was his classmate at Washburn. They were married 37 years ago. Children who survive are: Mrs. Henry S. DuBois, Jupiter, Fla.; Mrs. Guy U. Vinson, Miami; Mrs. Wilford Snare, Miami; John B. Tower, Homestead; A. Douglas Tower, Homestead; Mrs. Robert S. McLeroy, Miami, and Mrs. Cecil Dodd, Homestead. He is also survived by nine grandchildren.

### MEDICAL DISTRICT MEETINGS 1939

	Marianna (A) . . . . .	July 20
	Palatka (C) . . . . .	Sept. 14
	Lakeland (D) . . . . .	Sept. 28
	West Palm Beach (F) . . . . .	Oct. 12
	Ocala (B) . . . . .	Oct. 26
	Sanford (E) . . . . .	Nov. 9

*Any member who wishes to read a scientific paper at his district meeting is urged to make application immediately. From applications received four essayists will be selected by the senior councilor in each district. Mail your application to Box 1018, Jacksonville, Florida.*



## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

Dr. and Mrs. Daniel H. Funkenstein of Jacksonville announce the birth of a son, Herrman Harris, on Monday, May 22, in St. Vincent's Hospital. Mrs. Funkenstein was formerly Miss Hannah Bessie Harris.

### MARRIAGES

Dr. Harold G. Nix and Miss Jean Gilmer, daughter of Dr. E. S. Gilmer of Tampa, were married recently.

\* \* \*

Dr. Allen P. Gurganious of Palatka and Miss Elizabeth Clark Hoster of New York City were married on June 2 at the Chapel of St. Bartholomew's in New York.

### DEATHS

Dr. J. Lewis Pierce of Marianna died May 27 in a Thomasville, Georgia, hospital of injuries sustained in an automobile accident the preceding day.

\* \* \*

Dr. J. B. Tower of Homestead died April 13, following an illness of several years.

## COMPONENT COUNTY SOCIETIES

### DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society held its May meeting on the evening of the 10th in the Ingraham Building. The following scientific program was enjoyed:

"Internal Fixation of Transcervical Fractures of the Hip," by Arthur H. Weiland; discussion by Ferdinand A. Vogt.

"Treatment of Severe Acidosis in Children," by Lynn W. Whelchel; discussion by George N. Leonard and Warren Quillian.

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### DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto - Hardee - Highlands County Medical Society held a meeting on the evening of April 11 at Wauchula at which Dr. J. L. Hargrove of Bartow was guest speaker. Doctor Hargrove presented a paper on "Operation for Rupture of Gastric Ulcers." Dr. R. L. Hughes of Bartow was also a guest of the society.

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### DUVAL COUNTY MEDICAL SOCIETY

At the May meeting of the Duval County Medical Society, held in the Library of the State Board of Health Building, May 4, Drs. T. Z. Cason and R. H. Cox presented a paper on "Diabetes Mellitus: Analysis of Cases Treated in the Outpatient Department of the

Duval County Hospital During the Past Twelve Years." This was followed by a business meeting and the serving of refreshments.

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### LEON-GADSDEN-LIBERTY-WAKULLA- JEFFERSON COUNTY MEDICAL SOCIETY

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held its quarterly meeting on the afternoon of April 20, at Wakulla Springs. Four scientific papers constituted the program:

"Prostatic Obstruction and its Treatment," by Harold P. McDonald, Atlanta; "Treatment of Ingrowing Toe Nails," by A. O. Lynch, Atlanta; "Report of Three Cases of Rheumatic Fever," by F. T. Holland, Tallahassee; and "Hypertensions in General Practice," by Edward Annis, Tallahassee.

At the conclusion of the program a dinner was enjoyed by the attending physicians and their ladies.

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### PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. R. D. Sistrunk entertained the Pasco-Hernando-Citrus County Medical Society at the Edwinola Hotel, Dade City, Thursday evening, May 11. Dinner was enjoyed at the hotel, followed by a scientific program.

Dr. L. C. Gonzalez of Jacksonville was present with his sound projector and technical films on syphilis and showed a fine series of pictures with which he gave a lecture on each phase of the treatment of syphilis. The pictures and lecture were enjoyed by all members present and Doctor Gonzalez was extended the thanks of the Society for bringing this interesting program.

Dr. William H. Walters of Lacoochee reported on the meeting of the State Association which was held in Daytona Beach.

At the invitation of Dr. P. J. Hudson and W. B. Moon, who will act as hosts, it was decided to hold the June meeting in Crystal River.

Those present were: Drs. J. T. Bradshaw, G. R. Creekmore, W. W. Jones, H. L. Harrell, S. C. Harvard, D. B. Manley, R. D. Sistrunk, W. H. Walters, and the guest speaker, Dr. L. C. Gonzalez.

## PINELLAS COUNTY MEDICAL SOCIETY

Dr. L. B. Mount was principal speaker at the meeting of the Pinellas County Medical Society held at the Chatterbox on the evening of April 21. His paper, "Granuloma Inguinale," was discussed by Dr. A. L. Mills.

At the meeting of the Society held May 5, Dr. D. M. Hoyt was guest speaker, presenting an interesting paper on "Endemic Typhus."

An Academy program has been arranged by the Scientific Program Committee of this Society, to serve as a continuous postgraduate course in medicine and surgery. It will replace the second meeting of the month. One speaker in medicine and one in surgery will be selected from the membership who shall lecture for thirty minutes each as they would to a class of senior medical students and follow a prescribed outline of presentation. The lectures will be of general interest and not open for discussion or questioning; emphasis will be placed on anatomy, physiology and pathology.

In addition, a 20-minute lecture will be given at each meeting on one of the various limited fields of medicine and surgery, such as ophthalmology, dermatology, urology, psychiatry, etc., by a member or a visiting physician.

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## POLK COUNTY MEDICAL SOCIETY

Dr. Exum Walker of Atlanta was guest speaker at a meeting of the Polk County Medical Society held on the evening of May 10 at the Morrell Memorial Hospital, Lakeland. Thirty doctors were present at the dinner served by the hospital.

Dr. Walker's interesting paper on "The Practical Aspects of Common Neurosurgical Problems," was illustrated with lantern slides.

**ADVERTISERS' NOTES**

## FUNDUS OCULI STUDIES

American Optical Company has just published a booklet—"The Ophthalmoscope and Studies of the Fundus Oculi in Important Pathological Conditions"—which presents a series of fundus oculi studies, showing pathological changes from normal frequently encountered in diagnostic work.

The charts contained in the booklet were drawn by an anatomical artist under the direct supervision of an ophthalmologist of wide reputation. They depict actual cases observed in one of the large medical centers.

Although the book is not intended, in any sense, to be a treatise on ophthalmoscopy, AO hopes that the skill and fidelity with which the artist has depicted a number

of common diseases in their incipient stages and the clarity with which the author has described these fundamental conditions will prove helpful.

AO presents this study as an interesting contribution to current literature on ophthalmoscopy. Copies can be obtained free of charge from the company.

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IMMUNIZATION AGAINST DIPHTHERIA AND  
TETANUS

In days past, fabulous sums were paid for the bezoar stone, which superstition credited with having powerful curative and protective properties. Ambroise Pare convincingly disproved its value, but many persons, including Charles IX of France, continued to believe in the object's mythical influence. Humans today might conceivably be employing the stone were it not for modern science, which has developed many specifics for the prevention of disease.

One such product is Combined Diphtheria Toxoid-Tetanus Toxoid, Alum Precipitated, Lilly, indicated for simultaneous active immunization against diphtheria and tetanus. Clinical studies demonstrate that each toxoid acts independently to produce its homologous antitoxin. Immunity is established within three to six months after immunization.

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THE UNSPECIFIED PRESCRIPTION

Some physicians are averse to specifying the maker's name of a proprietary product.

"I invariably specify Mead's whenever I can, for I feel that when I do not specify a definite brand, the effect may be the same as specifying that any brand will do.

"By not specifying exactly, I let down the bars to a host of houses, many entirely unknown to me and others deserving no support at my hands.

"When I specify Mead's, I may be showing favoritism, but at least I know that I am protecting my results. If, at the same time, my self-interested act encourages a worthy manufacturer to serve me better, I can see no harm in that."

Mead Johnson & Company, Evansville, Ind., U. S. A., have to depend upon the physician to specify MEAD'S because they do not advertise their products to the public, either directly or through merchandising channels.

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SQUIBB INSTITUTE FOR MEDICAL RESEARCH

The Division of Organic Chemistry is carrying on research concerning the isolation, concentration, and chemical structure of vitamin K. Another study in progress under direction of Dr. Fernholz in collaboration with Doctor Archie Black deals with the isolation and purification of vitamin B<sub>6</sub>, lack of which is related to the occurrence of the chronic disease pellagra. Dr. Fernholz is also collaborating with Dr. Ansbacher on the filtrate factor of vitamin B complex. The Division's program also includes a theoretical investigation in the field of steroids.

The Division of Pharmacology, under Dr. van Dyke, is attempting to isolate and purify some of the hormones of the pituitary body. Dr. van Dyke describes the pituitary gland as the most interesting of the glands of internal secretions because it rules or coordinates the action of all other glands. For the present, the research concerns chiefly the anterior pituitary hormones, which maintain the ovaries and testes.

Another investigation proceeding in the Division of Pharmacology deals with new chemotherapeutic compounds. This work is being done in collaboration with the Medicinal Chemistry Laboratory and the Division of Bacteriology and Virus Diseases. The Division of Pharmacology will also foster research in the field of synthetic medicinal remedies for the treatment of cardiovascular diseases.



## ABSTRACT DEPARTMENT

*Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.*

**Meningioma of the Lateral Ventricle: Report of 2 Cases, LYERLY, J. G., Jacksonville, *Arch. Neurol. and Psychiat.* p. 997 (November), 1938.**

Meningiomas of the lateral ventricles are rare in occurrence, about eight having been reported in the literature. These tumors are firm, encapsulated growths attached to the choroid plexus, which is explained on the basis of the choroid plexus carrying with it remnants of the pia-arachnoid in its development from the neural crest. These tumors, pathologically, reveal numerous fibroglial and collagenous fibres such as are seen in the fibroblastic types of meningiomas. All the reported cases have occurred in women.

Lyerly reports two cases, both in women, both developing soon after the termination of pregnancy. The symptoms were those of increased intracranial pressure without definite localizing signs so that ventriculographic studies were made in both cases with localization made on the basis of distortion of the ventricles. Both were operated upon; both tumors found encapsulated and removed entirely. Both patients recovered and remained well, one without residual symptoms, the other with some weakness of the muscles on one side and mild aphasia.

**Two Unusual Cases of Cranial Osteomyelitis, ROSE, JOSEPH, Jacksonville and SCHAPIRO, MARK M., Washington, D. C., *Med. Ann. Dist. of Columbia*, 7: 323 (October), 1938.**

Cranial osteomyelitis is infrequent and seems to be decreasing because of better knowledge of the etiology and prophylaxis. It is rare after injury and usually follows disease of the nasal accessory sinuses or the otologic apparatus. The infection seems to result from extension of infection in the soft parts, the superior maxilla, the sinuses or the ear, and commonly is a complication of operation on these structures, rather than a spontaneous extension of infection. Cranial osteomyelitis after operations on the nasal accessory

sinuses is more common than after operations on the otologic apparatus and much more common than extensions of infection from the superior maxilla.

Rose and Schapiro report two cases of cranial osteomyelitis, the first a severe infection of the maxillary sinus followed by osteomyelitis of the orbital portions of the upper maxilla and zygoma. This patient had a long, stormy course complicated by osteomyelitis of the scaphoid bone, positive blood cultures for *Staphylococcus albus*, and infection in the lungs. Recovery in this first case was not complete at the time of last observation. The second report concerns that of cranial osteomyelitis following middle ear infection and mastoiditis. This patient also had a long, stormy course complicated by two periods of pneumonia, and a recurrence of infection in the infected bone some weeks after it seemed well.

---

**A Method for Treating Displaced Fractures of the Pelvis, JEWETT, EUGENE L., Orlando, *J. Bone & Joint Surg.* 21: 177-181 (January), 1939.**

Displaced fractures of the pelvis are difficult to treat and often heal by fibrous union. Even though disability and discomfort from such malunion may be slight, both scientific proficiency and a desire for a more stable pelvis after such injuries led the author to devise a well-leg traction method for the reduction of such fractures. A similar method had been used and described previously (though unknown to the author) by Jahss and also by Magnuson.

The method described by Jewett depends on the application of casts and Steinmann pins on both legs with turnbuckles between the legs above the knees and on the end of the cast of the affected leg so that traction downward and pressure outward can be exerted simultaneously on the fractured pelvis. After the reduction is accomplished the casts remain in place for six to eight weeks. Instead of the usual pelvic sling used in these cases, the author used a tight moleskin bandage around the pelvis. He reports a case of multiple pelvic fractures and sacroiliac separation successfully treated by this method with good clinical and anatomical results.

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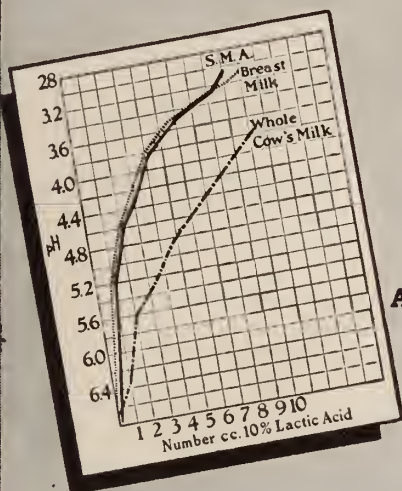
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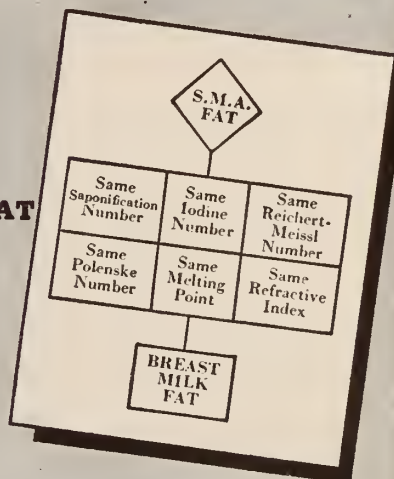
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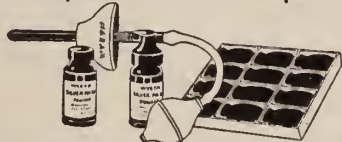
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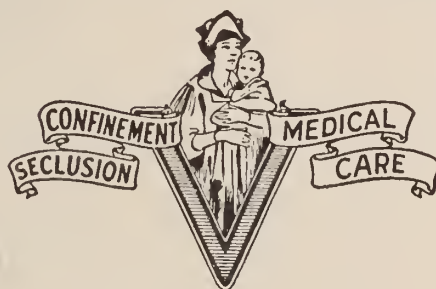
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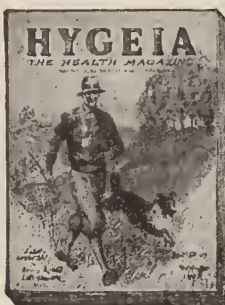
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## COMPONENT SOCIETIES BY DISTRICTS — FLORIDA MEDICAL ASSOCIATION

Dis- tricts	COUNTY SOCIETIES	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR and Counties Not In- cluded in First Column	Members	
						Total	Paid
Northwest District (A) Marianna July 20, 1939	Bay	Donald S. Fraser, M.D. Panama City	William C. Roberts, M.D. Panama City		A-1-'40 Carol C. Webb, M.D. Pensacola	12	100%
	Escambia	L. C. Fisher, Jr., M.D. 816 N. Palafox St. Pensacola	J. M. Hoffman, M.D. 1221 E. DeSoto St. Pensacola	2nd Tuesday 8:00 P. M.		44	34
	Walton-Ocalaosa	A. G. Williams, M.D. Lakewood	R. B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	W. D. Ramsey, M.D. Noma	L. H. Paul, M.D. Bonifay		Santa Rosa	8	7
	Franklin-Gulf	Chapman Dykes, M.D. Carrabelle	A. J. Ward, M.D. Port St. Joe	3rd Thursday	A-2-'41 B. A. Wilkinson, M.D. Tallahassee	6	100%
	Jackson	C. J. Price, M.D. Alford	R. N. Joyner, M.D. Marianna	2nd Tuesday 7:30 P. M.		14	12
	Leon-Gadsden Liberty- Wakulla-Jefferson	W. W. Massey, M.D. 204 N. Madison St. Quincy	B. A. Wilkinson, M.D. Telephone Bldg. Tallahassee	Quarterly 3:00 P. M.	Calhoun	40	34
North Central District (B) Ocala October 26, 1939	Columbia	W. M. Ives, M.D. 132 N. Marion St. Lake City	Harry S. Howell, M.D. Blanche Hotel Annex Lake City	1st Monday 7:30 P. M.	B-3-'41 W. S. Nichols, M.D. Lake City	21	16
	Madison	E. Long, M.D. Madison	A. F. Harrison, M.D. Madison			3	2
	Taylor	Geo. H. Warren, M.D. Perry	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P. M.	Baker-Dixie-Hamilton- Lafayette-Suwannee	8	6
	Alachua	J. E. Maines, Jr., M.D. 433 E. Main St. N. Gainesville	J. Maxey Dell, Jr., M.D. 333 W. Main St. S. Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M.D. McIntosh	28	21
	Marion	Carl S. Lytle, M.D. Dunnellon	R. C. Cumming, M.D. Commercial Bank Bldg. Ocala	3rd Thursday 12:30 P. M.		23	100%
	Pasco-Hernando- Citrus	Claude L. Carter, M.D. Inverness	G. R. Creekmore, M.D. Brooksville	2nd Thursday 7:00 P. M.		15	100%
	Sumter	Clyde L. Carter, M.D. Wildwood		2nd Tuesday	Bradford-Gilchrist- Levy-Union	3	2
N. E. District (C) Palatka September 14, 1939	Duval	Thomas E. Buckman, M.D. 1022 Park St. Jacksonville	Lauren M. Sompayrac, M.D. 459 St. James Bldg. Jacksonville	1st Tuesday 8:15 P. M.	C-5-'41 R. B. Melver, M.D. Jacksonville	173	169
	St. Johns	R. D. Harris, M.D. St. Augustine	G. Walter Potter, M.D. East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	Clay-Nassau	10	100%
	Putnam	Edward W. Ford, M.D. Crescent City	C. M. Knight, M.D. Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M.D. Daytona Beach	10	9
	Volusia	Maximilian Stern, M.D. Box 5095 Daytona Beach	R. L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P. M.	Flagler	41	37
Southwest District (D) Lakeland September 28, 1939	Hillsborough	J. W. Alsobrook, M.D. 120 N. Collins St. Plant City	James S. Grable, M. D. 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P. M.	D-7-'41 W. C. McConnell, M.D. St. Petersburg	108	88
	Manatee	S. G. Hollingsworth, M.D. 451 12th St. Bradenton	M. M. Harrison, M.D. Professional Bldg. Bradenton	3rd Tuesday 7:00 P. M.		13	100%
	Pinellas	E. C. MacCordy, M.D. 366 First Federal Bldg. St. Petersburg	W. C. McConnell, M.D. 1001 First Federal Bldg. St. Petersburg	1st and 3rd Fridays 6:30 P. M.		93	100%
	Sarasota	T. W. Taylor, M.D. Professional Bldg. Sarasota	Stanley T. Martin, M.D. Sarasota	2nd Tuesday 8:30 P. M.		17	10
	DeSoto-Hardee-High- lands-Charlotte- Glades	Ben D. Spears, M.D. Wauchula	Howard V. Weems, M.D. 22 Oak St. Sebring	2nd Tuesday 8:00 P. M.	D-8-40 Herman Watson, M.D. Lakeland	19	100%
	Lee	C. Gordon Merriew, M.D. 26 Leon Bldg. Fort Myers	H. L. Allan, M.D. 312 Pythian Bldg. Fort Myers	3rd Friday 7:30 P. M.		14	11
	Polk	John F. Wilson, Jr., M.D. Box 254 Lakeland	J. R. Boulware, Jr., M.D. P. O. Box 367 Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	Collier-Hendry	62	100%
South Central District (E) Sanford November 9, 1939	Brevard	W. J. Creel, M.D. Eau Gallie	I. K. Hicks, M.D. Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M.D. Cocoa	11	7
	Lake	W. G. DeVane, M.D. Groveland	Oliver Emerson, M.D. Tavares	1st Thursday 12:30 P. M.		18	13
	Orange	C. D. Hoffmann, M.D. 120 E. Robinson St. Orlando	Fred Mathers, M.D. Box 53 Orlando	3rd Wednesday 8:30 P. M.		77	72
	Seminole	Thomas F. McDaniel, M.D. Seminole County Bank Bldg. Sanford	Donelas G. Scott, M.D. 212 N. Park Ave. Sanford	2nd Monday 7:00 P. M.	Osceola	12	100%
	St. Lucie-Okeechobee Indian River-Martin	J. D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'41 A. M. Sample, M.D. Ft. Pierce	17	100%
S. E. District (F) West Palm Beach October 12, 1939	Broward	R. L. Elliston, M.D. 814 Sweet Bldg. Ft. Lauderdale	Oliver C. Brown, M.D. 915 Sweet Bldg. Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M.D. West Palm Beach	33	100%
	Palm Beach	Gaylord Lewis, M.D. 916 Harvey Bldg. W. Palm Beach	C. Jennings Derrick, M.D. Box 574 W. Palm Beach	4th Monday 8:00 P. M.		58	100%
	Dade	M. Jay Filipse, M.D. 305 Huntington Bldg. Miami	Franz Stewart, M.D. 1105 Huntington Bldg. Miami	1st Tuesday 8:30 P. M.	F-12-'41 Kenneth Phillips, M.D. Miami	296	262
	Monroe	Harry C. Galey, M.D. 532 Fleming St. Key West	W. R. Warren, M.D. 511 Eaton St. Key West	1st Sunday 9:00 P. M.		4	100%



STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Leigh F. Robinson, Ft. Lauderdale	Shaler Richardson, Jacksonville....	Tampa, 1940
Florida Medical Districts:			
A—Northwest .....	Carol C. Webb, Pensacola .....	Stewart Thompson, Jacksonville...	Marianna, July 20, 1939
B—North Central .....	J. L. Strange, McIntosh.....	" " "	Ocala, Oct. 26, 1939
C—Northeast .....	George M. Green, Daytona Beach..	" " "	Palatka, Sept. 14, 1939
D—Southwest .....	Herman Watson, Lakeland.....	" " "	Lakeland, Sept. 28, 1939
E—South Central .....	W. C. Page, Cocoa.....	" " "	Sanford, Nov. 9, 1939
F—Southeast .....	Lloyd J. Netto, West Palm Beach..	" " "	West Palm Beach, Oct. 12, 1939
Alabama Medical Association.....	M. S. Davie, Dothan.....	D. L. Cannon, Montgomery.....	Birmingham, April 16-18, 1940
Georgia, Medical Assn. of .....	Grady N. Coker, Canton.....	E. D. Shanks, Atlanta.....	
Florida—			
State Dental Association.....	R. P. Taylor, Jacksonville.....	E. C. Lunsford, Miami.....	West Palm Beach, Oct. 12-14, 1939
Soc. of Derm. and Syph. ....	Elmo D. French, Miami.....	Lauren M. Sompayrac, Jacksonville	Jacksonville, Nov. 1939
East Coast Medical Association	Frederick J. Waas, Jacksonville..	A. J. Logie, Jacksonville.....	Jacksonville, Nov. 10-11, 1939
State Hospital Association .....	J. H. Therrell, Chattahoochee....	Mr. Fred M. Walker, Jacksonville..	Mississippi, March, 1940
Assn. of Industrial Surgeons.....	C. E. Tumlin, Miami.....	A. M. Bidwell, Tampa.....	Tampa, 1940
Internists' Society.....	Norval M. Marr, St. Petersburg..	Kenneth Phillips, Miami.....	Tampa, 1940
Medical Postgraduate Course...	Turner Z. Cason, Jacksonville....	Chairman	Daytona Beach, June 19-24, 1939
State Nurses Association.....	Mrs. Inez Nelson, Orlando.....	Mrs. Phyllis Leonard, St. Augustine	Lakeland, Nov. 6-8, 1939
Pediatric Society .....	Warren W. Quillian, Coral Gables	G. N. Leonard, Miami Beach.....	Tampa, 1940
Pharmaceutical Association .....	Mr. R. Q. Richards, Ft. Myers....	Mr. A. W. Morrison, Miami.....	Hollywood Beach, May, 1939
Public Health Association .....	Mr. S. D. Macready, W. P. Beach	E. M. L'Engle, Jacksonville.....	Jacksonville, 1939
Radiological Society .....	H. B. McEuen, Jacksonville.....	J. N. Moore, Ocala.....	Tampa, 1940
Railway Surgeons' Association...	Herman Watson, Lakeland.....	H. D. Clark, Ft. Pierce.....	Tampa, 1940
Tuberculosis & Health Assn....	Mr. G. E. Therry, W. Palm Beach	Mrs. May Pyncheon, Jacksonville..	Spring, 1940
Chattahoochee Valley Med. Assn.	J. S. Turberville, Century.....	Frank K. Boland, Atlanta.....	Albany, Ga., July 11-13, 1939
Gulf Coast Clinical Society.....	J. H. Dodson, Mobile.....	C. C. Rouse, Mobile.....	Mobile, Oct. 26-27, 1939
Internat. Assn. Milk Sanitarians	Mr. V. M. Ehlers, Austin, Texas	Mr. C. Sidney Leete, Albany, N. Y.	Jacksonville, Oct. 25-27, 1939
Southeastern Derm. Assn.....	J. R. Allison, Columbia.....	Howard King, Nashville.....	Nashville, Sept. 3, 1939
Southeastern Surgical Congress...	R. L. Sanders, Memphis.....	B. T. Beasley, Atlanta.....	Birmingham, Mar. 11-13, 1940
Southern Medical Association .....	W. E. Vest, Huntington, W. Va.	Mr. C. P. Loranz, Birmingham....	Memphis, Nov. 21-24, 1939
Suwannee River Medical Society..	T. H. Bates, Lake City.....	H. S. Howell, Lake City.....	

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